Self concept and attributions about other women in women with a history of childhood sexual abuse.

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To Martin, for being there no matter what.

To my family, with love.

Abstract

OBJECTIVE: To investigate self concept and attributions about other women of women with a history of childhood sexual abuse (CSA) using an adapted version of the self-concept card sorting task (Zajonc, 1960).

METHOD: A mixed design was used to compare three groups of women: women with a history of CSA, women experiencing depressed mood but without a history of CSA and a healthy non-clinical comparison group of hospital staff. A between-subjects design was used but correlational analyses were also conducted.

RESULTS: General self concept was found to differ significantly between groups. Significant differences were also found between groups when considering the initial self concepts that came to mind for each woman (e.g. mother, wife, daughter). However, this difference ceased to be significant as further roles were discussed. Few significant differences were found between groups when comparing attributions about other women, although a priori analysis revealed that the healthy non-clinical comparison group made more positive attributions about mothers than the CSA group and fewer negative attributions about mothers than the depression group.

CONCLUSION: To some extent the current findings support previous studies indicating women attempting to cope with the consequences of a history of CSA have a negative self concept. However, there is evidence to suggest that certain self-aspects are protective or protected. Similarly there is some support for previous

evidence of difficult relationships with mothers. Possible explanations for these findings are discussed and areas for future research suggested.

1 Introduction

1.1. General overview

Childhood sexual abuse (CSA) can have a profound impact on a survivor's personality. Despite such experiences in early life, a survivor must attempt to develop trust, a sense of safety and control from a situation that is unpredictable and which leaves them powerless. In this review of the literature about self concept and attributions made about others, a definition of CSA is provided initially, along with an indication of prevalence rates. The resulting mental health problems are outlined and the impact of a history of CSA is discussed, both in terms of intrapersonal and interpersonal aspects. Two currently popular treatment models are described before detailing the rationale for this study, its aims and hypotheses.

1.2 Childhood Sexual Abuse (CSA)

1.2.1 Definition

Any author writing about CSA faces the initial challenge of defining CSA. Opinions differ across countries and cultures on a number of issues: how one defines a child, (i.e. at what age one is considered an adult) if an individual is considered a child, how many years older another person would have to be for that relationship to be considered abusive and which activities are categorised as abusive (e.g. the inclusion or exclusion of abuse that does not involve physical contact).

For the purposes of this study, the definition of CSA given by the Centre of Child Abuse and Neglect (NCCAN) will be employed, as this is where Finkelhor (1997),

whose model of CSA is widely used by those working both with victims and perpetrators of CSA, draws from. CSA is defined as:

> *'Contacts or interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person. Sexual abuse may also be committed by a person under the age of 18 when that person is significantly older than the victim or when the perpetrator is in a position of power or control over another child.' (NCCAN, 1978:2, cited in Finkelhor, 1997)*

The author notes that this definition is clinically relevant for a number of reasons: the underpinning concept is the exploitation of a power differential which can include a maturation advantage, it incorporates both contact and non-contact abuse and it covers abuse both within and outwith the family.

It is also important to be aware that sexual abuse often does not occur in isolation. Physical abuse, neglect and psychological abuse are commonly associated with CSA, so any research conducted in this area needs to take account of these potential confounding variables (Bifulco & Moran 1998, Drauker, 2000, Pollock, 2001). For example, Wind and Silvern (1992) reported that women who had been both sexually and physically abused experienced more symptoms of trauma, lower self-esteem, more sexual dysfunction and lower mood than women who had experienced sexual abuse or physical abuse alone.

Whilst bearing in mind these difficulties regarding definition, given increasing awareness about the occurrence of CSA, it is important to have some concept of the scale of the problem.

1.2.2 Prevalence rates

As indicated, issues of differing definitions employed and the presence of other types of abuse need to be considered when studying reported prevalence rates. Furthermore, a variety of methodologies has been employed in research studies about CSA. These can be divided into those conducted with children, those conducted with parents and retrospective studies with adults regarding history of CSA in their own childhood. Consequently, reported prevalence rates vary considerably. Nevertheless, international studies conducted between 1980 and 2002 indicate that CSA is a global problem (Finkelhor, 1994). For women the mean lifetime prevalence is 20% and for men it is 5–10%. Consequently, The World Health Organisation (WHO, 2002b) lists CSA among its 25 leading global risks to health.

To provide some examples of the differing prevalence rates, one Australian study conducted by Goldman and Padayachi (1997) reported a 1% prevalence rate of CSA among men. Conversely, in a longitudinal study of CSA among Norwegian men, Pederson and Skrondal (1996) reported a prevalence rate of 19%. A definition of sexual contact involving pressure or force was employed in the first study whereas a broader definition was used in the latter study, which could account for this significant discrepancy. Similarly, differences in reported prevalence rates of CSA among women are exemplified by comparing Choquet *et al.'s* (1997) French study of

adolescent rape victims with Pederson and Skrondal's (1996) study. The former reported a prevalence rate of 0.9% whereas the later found a prevalence rate of 45%. Closer to home, the Scottish Executive (2005) notes that although prevalence rates of 12% for females and 8% for males have previously been considered applicable in the UK, these figures may have underestimated the actual level. However, a campaign of increased awareness of child protection issues has aimed to raise public awareness of abuse and its long-term consequences.

In relation to the current study, it is important to note that in most countries, victims of sexual abuse are more likely to be female than male. In a review of the epidemiology of CSA, Finkelhor (1994) found rates of sexual abuse to be up to three times higher for females than males. He also found that the highest rates of CSA occur during adolescence and men are the predominant abusers of both male and female children, with figures suggesting that 90% or more of abusers of females are males, and between 63% and 86% of abusers of males are males.

Therefore, given the scale of the problem, it is important to improve understanding of the complexities of the repercussions of CSA on the lives of female survivors.

1.2.3 Impact on individuals

Indeed, Baker and Duncan's (1985) national survey of the British population investigated the long-term effect on those 119 women in their sample whom they found had a history of CSA. Thirteen percent reported that they had been permanently damaged by their experiences. Fifty-one percent described the abuse as

being unpleasant and harmful at the time, but did not feel there had been any long-lasting effects. Thirty-four percent described no effects at all and two percent said the experience had improved the quality of their lives. However, it is important to acknowledge that this study was conducted more than 20 years ago, at a time when the issue of CSA was just beginning to be recognised. Notably, Peleikis and Dahl (2005) observe that the first empirical trial into the effects of CSA was not published until 1989. That being the case, it can be suggested that there was less understanding and acceptance of the scale of the problem and perhaps women felt unable to openly discuss the impact of CSA on their lives.

Certainly, Bifulco and Moran (1998) report that in the long-term, sexual abuse can have serious consequences for psychological and social development:

> *'...under some conditions, this results in individuals entering adulthood too damaged to cope with the demands of everyday living and raising the next generation of children.' (Bifulco and Moran, 1998, p.2)*

Briere (2002) is more specific, suggesting that a history of CSA can result in emotional instability, distorted cognitions, symptoms of post traumatic stress disorder (PTSD) and longstanding interpersonal difficulties. Importantly, WHO's (2002a) Report on Violence and Health accounts for potential differences in coping by explaining that the consequences of abuse for the individual vary depending on the age at which the abuse occurs, the duration and severity, the relationship of the perpetrator to the child and other environmental factors.

Although this review will focus on the mental health problems experienced by survivors along with the intra- and interpersonal difficulties they experience, it is important to remember, given the relative demand on resources, that other studies have also shown that for some women, their distress can manifest in physical health problems, with survivors shown to be at higher risk for certain medical problems including those of a gynaecological and gastrointestinal nature (Salmon & Calderbank, 1996; Roberts, 2000; Nelson, 2002) and for yet others they may become involved in forensic services. For example, the Scottish Executive (2005) found that many prisoners; particularly female prisoners, in Scotland's jails, have a history of CSA and £30-60 million per annum of NHS money is spent on management of the health consequences of CSA for women in Scotland. Consequently, in the same year, the Scottish Executive introduced a national strategy for working with survivors of CSA. The primary aim was to improve quality of life by creating more joined-up services that would be better able to respond to the effects of past abuse. This strategy can be linked to recommendations made in WHO's Report on Violence and Health (WHO, 2002a).

Some of the most common mental health issues associated with a history of CSA will now be discussed, with reference to possible contributory and protective factors.

1.3 Mental health issues associated with CSA

1.3.1 Background

Numerous studies have found that a history of CSA is associated with increased risk of developing a range of problems that might require input from mental health

services, including alcohol dependence and substance misuse (Beitchman *et al.*, 1991; Beitchman *et al.*, 1992; Jumper, 1995). It is important to examine the relationship between CSA and mental health difficulties in later life, given that these women are likely to be significant users of health services. As a consequence of this, risk and protective factors can be identified and treatments developed and adapted.

Studies of clinical samples, like those conducted by Bryer *et al.* (1987) and Carmen *et al.* (1984), note that chronic, recurrent, and more severe psychiatric disorders, including depression, have been shown to be associated with a history of abuse. This is supported by longitudinal research. For example Fergusson *et al.* (1996) found those with a history of CSA were more likely to experience common psychiatric problems like major depression, anxiety disorders, substance misuse and suicidality than those without a history of CSA. Jehu's (1988) University of Mannitoba study indicated that the main psychological difficulties associated with a history of CSA could be encompassed under the one umbrella of PTSD type symptoms and mood disturbance. This included intrusive memories of the abuse, flashbacks, nightmares, avoidance, anxiety and hypervigilance as well as depression, low self-esteem, and guilt, which was thought to lead to self-harm, eating disorders, obsessive-compulsive symptoms and avoidance.

Further, Briere and Zaidi (1989) found evidence to suggest that survivors also account for a large proportion of acute presentations. In a sample of 100 non-psychotic females attending for emergency psychiatric treatment, the authors noted that women with a history of CSA were more likely to have sexual problems, a

history of drug abuse, suicidal ideation, a history of suicide attempts or self-mutilation and have a diagnosis of personality disorder than women without a history of CSA. Therefore, survivors can come into contact with an extensive range of services, and are likely to be asked to explain their history to numerous different people, some of who will have a greater appreciation of their difficulties than others.

In a clinical control trial, Romans, Martin, Anderson, O'Shea, *et al.* (1995) compared the prevalence of various mental health problems in female abuse survivors and non-abuse controls. Significant differences were found between the groups in terms of the percentage who had depression, phobias and eating disorders. In addition, although no significant differences were found for anxiety or mania, overall, survivors were more likely to have a mental health problem than controls. The authors noted that the single biggest problem was depressed mood and that survivors also had significantly lower self-esteem. However, arguably, a particularly important contribution of this research was its focus on investigating possible mediating factors between CSA and psychological well being as an adult. Findings indicated that poor family relationships e.g. lack of physical affection or presence of domestic abuse, poor high school performance and early pregnancy were all related to poor outcome. In contrast, the authors found that a good adolescent relationship with one's father, good academic or sporting performance at school and good relationship with a partner were all associated with a good outcome. It was proposed that achievement is likely to have a positive impact on self esteem and so act as a protecting factor. Moreover, a good relationship with one's partner was considered to be more powerful than psychological intervention.

Accordingly, it can be suggested that this research indicates that although CSA may be related to higher rates of psychiatric morbidity, it is not a foregone conclusion. However, it can be argued that it is difficult to differentiate between cause and effect with these variables. For example, it could be considered that good mental health may enable a survivor to have a good relationship with a partner but conversely, a good relationship with a partner may facilitate good mental health. Thus, as discussed earlier, given that sexual abuse often does not occur in isolation, some authors have reasoned that the differences between those who have long-standing difficulties dealing with the effects of CSA and those who cope to a greater extent cannot simply be attributed to abuse effects, but are a consequence of a negative family system, which fosters an environment in which abuse can occur (Yama, *et al.*, 1993).

Briere (2002) for example, argues that although there is a strong link between CSA and poor mental health, many factors can mediate the type and severity of difficulties experienced.

> *'Childhood victimisation is a substantial risk factor for the development of later mental health problems. The specific psychological impacts of early maltreatment experiences vary as a function of a number of variables, including temperament and other biopsychological factors, family environment, security of parent-child attachment and previous history of support or abuse. In addition, it appears that the specific type of child abuse is, to some extent, related to the form of subsequent psychological distress or disorder.' (Briere, 2002, p.1)*

Thus temperament, attachment style, family environment, and intra- and inter-personal aspects all have a part to play. Given this myriad of factors, it is perhaps

unsurprising that survivors can experience a range of metal health problems. It is important to consider possible pathways that might make the experience of particular mental health problems more likely than others.

1.3.2 Depression

Studies indicate that depression is one of the most common mental health problems experienced by women, with females approximately two times more likely to develop depression than males (Kessler *et al.,* 1993). Given that numerous studies have suggested that experiences of CSA may lead to later depressive disorder (Andrews & Brown, 1988; Burnam *et al.,* 1988; Holmes & Robins, 1987) it seems probable that many women who present to services with depressed mood may also have a history of CSA and vice versa.

Certainly, Bifulco and Moran (1998) conducted interviews with a large sample of women and found that experiences of abuse in childhood play a significant role in the development of subsequent depression in adult life. Also, Mullen *et al.* (1988) found that in a New Zealand community sample, women with a history of CSA were in general, more likely to be considered in need of psychological intervention than non-abused controls and in most cases this was for depressogenic symptoms.

Nonetheless, theories as to the mediating factors between CSA and depression vary. In a longitudinal community sample, Andrews (1995) found that bodily shame was associated with chronic and recurrent depression in adult women with a history of abusive experiences. However, when Gladstone *et al.* (1999) investigated differences

between depressed women who had a history of CSA and those who did not, findings indicated that although those in the CSA condition scored higher on self-report measures of depression, there was no difference when mood severity was rated by psychiatrists. Nevertheless, those with a history of CSA did differ from those with no history of CSA in a number of other measures. Those in the CSA condition exhibited more self-destructive behaviour and borderline personality characteristics than those without a history of CSA. They also reported more experiences of childhood adversity overall. The authors suggest that depression in adulthood is likely to be mediated by a more broadly dysfunctional childhood environment. This conceptualisation is supported by Beitchman *et al.*'s (1992) review of the effects of CSA, which indicated that level of parental support and in particular the child's perception of her mother's reaction to the abuse, may be critical mediating factors.

1.3.3 Low self-esteem

Robson (1989) explained self-esteem as an individual's acceptance and satisfaction with their appraisal of themselves in terms of abilities, worth, attractiveness etc. CSA has been shown to have a substantial negative impact upon survivors' self esteem (Gold, 1986; Gorey *et al.*, 2001). For example, in a review of the symptoms reported most frequently by survivors, Stock (2002) found low self esteem to be one of the most prevalent. The author then conducted research with mental health professionals, who listed low self-esteem among the top three symptoms they encountered when facilitating groups for CSA survivors, providing support for the previous findings.

Notably, the degree of damage to levels of self-esteem has been shown to vary according to intrafamilial or interfamilial abuse. Rhoades (1996) reported self esteem scores of three groups of women: a group who had been sexually abused by a family member, women who had been sexually abused by a non-family member and non-abused women. Scores on the Rosenberg Self-esteem Inventory (Rosenberg, 1989) were significantly lower in the intrafamilial group than the other two groups, and the scores of the interfamilial group were significantly lower than those in the non-abused group. It can be suggested that this will have distinct repercussions for future interpersonal relationships, not least within the family of origin, and in particular a survivor's capacity to trust others.

In addition, often women who are abused as children are abused again in adolescence or adulthood. Again, this can have a marked impact upon self-esteem. In a group of 60 female psychiatric patients (inpatients and outpatients) Sahay *et al.* (2000) found that 65% had been sexually abused either in childhood or adolescence/adulthood. Many, (52%) had been sexually abused both in childhood and adolescence/adulthood. Global self-esteem was highest in those with no history of CSA, lower in those who had been abused in childhood or adolescence/adulthood and lowest in women who had been abused both in childhood and adolescence/adulthood. It can be suggested that multiple experiences of abuse may reinforce a self-perception of having some responsibility for the abuse and consequently have a particular impact upon self esteem.

1.3.4 Anxiety

The relationship between anxiety symptoms and CSA appears to be rather complex. For example, Pribor and Dinwiddie (1992) examined the correlation between adult psychiatric diagnosis and incest in childhood. They interviewed 52 female incest survivors and a comparison group of 23 age- and race-matched women. Results showed that there was a higher incidence of panic disorder, agoraphobia, social and simple phobia in the incest group than in the comparison group. On the other hand, in a study investigating severity of depressed mood and lifetime history of anxiety and depression in women with and without a history of CSA, Gladstone *et al.* (1999) found no difference in lifetime prevalence of anxiety disorders between the groups, with social phobia accounting for the majority of anxiety disorders in both.

In their review of the long-term effects of CSA, Beitchman *et al.* (1992) attempt to shed some light on these findings by quoting studies by Briere (1984) and Herman and Shatzow (1987). Briere (1984) reported that women with a history of CSA were more likely to describe anxiety attacks and in particular a fear of men, than women without a history of CSA. Furthermore, Herman and Shatzow (1987) showed that 26% of their sample fitted criteria for chronic, severe anxiety. However, Beitchman *et al.* (1992) point out that in both these studies women had been subjected to force or been threatened with force, therefore they suggest that it is unclear if this is a mediating factor between CSA and anxiety. It seems important to explore the use of force in a survivor's history, as this will have considerable implications for their ability to trust others, within their personal relationships but also in their lives in general.

1.3.5 Post traumatic stress disorder (PTSD)

Some authors (e.g. Goodwin, 1985; Rodrigues *et al.*, 1996: Roth *et al.*, 1997) have conceptualised the sequelae of CSA in terms of chronic PTSD. Certainly, in a study of CSA survivors, Lindberg and Distad (1985) reported that symptoms of PTSD, for example intrusive memories and flashbacks, were common and were often catalysts for survivors seeking treatment. Moreover, Craine *et al.* (1988) found that in a study of 105 psychiatric inpatients, more than half had a history of CSA and of these 66% met criteria for PTSD. However, research by Wolfe *et al.* (1994) indicated that the nature and severity of the sexual abuse and experience of guilt may be important factors in the difference between whether an individual was deemed to fit the criteria for PTSD or not.

Yet others have argued that a diagnosis of PTSD fails to adequately explain the experiences of women dealing with the consequences of CSA (e.g. Breire, 2002). Given that the concept of PTSD was developed from soldiers' experiences of shell shock, and has been used to explain reactions to relatively circumscribed events such as a car accident or a hostage situation, it has been argued that it is an inadequate diagnosis to capture the effects of CSA. Experiences of CSA are generally not one-off incidents, rather, they are often prolonged over a number of years and have a significant impact due to the early developmental age at which much childhood sexual abuse occurs, consequently, profoundly affecting a survivor's beliefs about the world from a very early age. Thus, Finkelhor (1987) for one, suggested that for many women, the experience of CSA is more covert, more longitudinal and is often

so intrinsically involved with the personality of the perpetrator that it becomes more relational. He considers PTSD as being more appropriate for conceptualising the impact of stranger rape, which is more likely to be a single incident, evoking feelings of overwhelming danger, rather than potential feelings of confusion associated with CSA. Therefore, the sequelae of ongoing, often interpersonal traumatic events that characterise CSA are likely to be more complex and more persistent. It is liable to include more characterological disturbances and involve greater vulnerability to repeated harm.

Certainly, Maercker (1999) found that PTSD could have a significant impact on interpersonal relationships, with those diagnosed with PTSD reporting increased divorce rates and other family problems. Also Perkonigg and Wittchen (1999) showed that PTSD is a highly co-morbid disorder, which is likely to co-occur with anxiety and depressive disorders, drug abuse and alcohol abuse. Therefore, it has been suggested that there is a requirement for a new diagnostic conceptualisation of disorders of extreme stress and chronic PTSD, which might be called complex PTSD (Herman, 1992).

1.3.6 Personality Disorder

Borderline Personality Disorder (BPD) is characterised by problems with identity and difficulties in self-other boundaries. An individual is likely to fluctuate between feelings of emptiness and intense dysphoria, have self-defeating cognitions, and respond with emotional outbursts and impulsivity when they perceive they have been abandoned, rejected, or mistreated by others (APA, 1994).

Several authors have discussed the possibility of a link between CSA and BPD, for example, Barnard and Hirsch (1985) reported that 57% of survivors in their study had a diagnosis of BPD and Bryer *et al.* (1987) found that 12 out of 14 patients with a diagnosis of BPD had a history of CSA. Briere (2002) draws parallels between complex PTSD and BPD by suggesting that the diagnostic features of PTSD: intrusive feelings, thoughts and memories characterised by an avoidance response, can also be applied to BPD. His self-trauma model proposes that the difference is that in BPD the memories activated relate to unprocessed material from childhood about interpersonal relationships, often, but not necessarily, involving experiences of sexual abuse.

For example:

> *'...an individual with borderline personality disorder, after being triggered by a perceived slight in an intimate relationship...might experience sudden, intrusive thoughts and feelings of abandonment and betrayal associated with childhood maltreatment and re-experience abuse-era desperation and anger associated with that memory. The individual might then engage in dramatic negative tension-reducing or proximity-seeking behaviour in the context of that relationship.' (Breire, 2002, p.9)*

As indicated by this quote, BPD can result in extreme fluctuations within the individual, to the extent that it is often extremely difficult for them and others to understand what has triggered the change in mood. Consequently, this can be extremely distressing for the individual and others to cope with. It is perhaps because of this that some authors have reported that the presence of comorbid personality disorder can make treatment more difficult (Dressen & Arntz, 1998).

1.3.7 Self harm and suicidal ideation

Self harm and suicidal ideation are also frequent among survivors, with particularly high rates in clinical samples but also substantial levels in community samples. Romans, Martin, Anderson, Herbison *et al.* (1995) examined the link between CSA and self harm by initially comparing two community samples of women, one with a history of CSA and one without a history of CSA. Subsequently, a subgroup of women with a history of CSA who self harmed was compared with those who did not self harm, but who did have a history of CSA. Results showed a significant association between history of CSA and deliberate self harm, with the strongest association in those who had experienced more intrusive and frequent abuse. In addition, Briere and Runtz (1986) compared survivors with non-abused controls and reported that more than half of the survivors had a history of suicide attempts compared with 23% of non-abused women. However, given that current suicidality was related to compound abuse (physical and sexual abuse) this may have been a confounding factor in the relationship between CSA and self harm.

Nonetheless, in a psychiatric inpatient population, Bryer *et al.* (1987) showed that women who had previously self harmed or experienced suicidal ideation, or made suicide attempts, were three times more likely to have a history of CSA. Also Van der Kolk *et al.* (1991), in a study involving women aged between 18 and 39 years with personality disorders or bipolar disorder, found a significant link between a history of CSA and self-injurious behaviour or suicide attempts. Self-injurious behaviour was also associated with dissociation.

Thus, these studies suggest that although the evidence for a link between CSA and self harm or suicidality is not conclusive and there may be other potential mediating factors, those with a more complex clinical history may be at increased risk.

1.3.8 Dissociation

Briere (2006) notes that dissociation is often thought to be associated with PTSD, and has been linked to a variety of traumatic experiences including warfare, natural disaster and CSA. However, he reports that in a sample of clinical and control individuals, exposure to trauma accounted for on average, only 4% of variance in experience of dissociation (Briere *et al.*, 2005). Nonetheless, in a study investigating the relationship between CSA and dissociation among female inpatients in a specialist trauma service, Chu *et al.* (1999) found that the prevalence of dissociative symptoms was significantly higher in those with a history of abuse than those who did not have such a history. Further, those with greater dissociative symptoms reported increased frequency of abuse and earlier age of onset. Also, Foote (2006) reports that in a mixed gender population of psychiatric outpatients, a significant difference was found in the incidence of CSA in those diagnosed with a dissociative disorder, compared to with those not given such a diagnosis, (74%: 27%).

Briere (2006) contends that there may be other explanations for the occurrence of dissociation, rather than necessarily a link with PTSD. He states that most people who dissociate have history of CSA, despite dissociation only accounting for 4% in those suffering trauma. He suggests that dissociation may be common in survivors

because it is used as a coping strategy to 'escape from' extreme trauma. The author cites other work that suggests that substance abuse, emotional neglect, panic attacks and neurobiological disturbance may all have a role to play in the experience of dissociation. He also points out that these factors may interact, for example emotional neglect is often a factor in attachment disorders and these may contribute to neurobiological vulnerability to stress. Difficulties in attachment have obvious implications for interpersonal relationships.

1.3.9 Substance abuse and alcohol misuse

Kendall-Tackett (2002) notes that adult survivors of childhood abuse are more likely to employ harmful coping strategies, including the abuse of alcohol and drugs. For example, Briere and Rutz (1987) showed that in comparison to a control group, women with a history of CSA were approximately 10 times as likely to have been addicted to drugs and twice as likely to have had an alcohol addiction. Grayson and Nolen-Hoeksema (2005) found evidence for both the distress coping model (drinking to cope with negative emotions) and the emotion regulation model (drinking to cope with negative emotions and drinking to enhance positive emotions) in a community sample of women with a history of CSA and alcohol-related problems, suggesting that women were abusing alcohol in an attempt to deal with sequelae of abuse. Also, in a study of female adult twins, Kendler *et al.* (2000) found that although CSA was strongly correlated with many psychiatric disorders, the strongest correlation was between CSA and alcohol/drug dependence. The use of such strategies has a negative

impact on general quality of life and is likely to have a destructive impact upon a survivor's relationships.

Thus, to summarise, the effects of CSA on the individual are significant and can take many forms. Survivors can experience a range of mental health difficulties and these can impact upon her interpersonal relationships. However, it is also important to consider the impact that the abuse can have upon a survivor's self concept and how this may provide a link between the mental health difficulties discussed and problems in interpersonal relationships. This will now be discussed in more detail.

1.4 Self concept

1.4.1 Models of self concept

In their traumagenic dynamics model, Finkelhor and Brown (1985) attempted to explain the factors that might mediate the impact of CSA on subsequent relationships and psychological difficulties. They proposed that a survivor's self concept, understanding of the world and affect are influenced by feelings of betrayal, powerlessness and a perception of being stigmatised, as well as the traumatic nature of sexualisation. The authors suggest that it is this combination of factors that has such a devastating impact on those with a history of CSA. In particular, they argue that the experience of powerlessness that is often central to a survivor's experience of CSA is likely to undermine her sense of mastery and efficacy and it may be these underlying aspects of the self concept that result in the experience of dissociation and symptoms of anxiety and depression. MacFarlane (1988, 1996) explains this in a similar way, proposing that for survivors, the traumatic component of their

experience develops not from the actual abuse but from their perception of what the abuse meant to them and it is this that affects their sense of self.

Much research has indicated that the self concept is multi-faceted; with various self aspects being constructed according to different situations, roles, personality traits, mood states and interactions with others and that consequently, we can perceive and present ourselves in different ways within different contexts (Kilstrom and Cantor, 1984). However, perhaps the above model (Finkelhor and Browne, 1985) suggests that for a survivor their general self concept may be largely negative.

As indicated, this section will look at how self concept may be understood before consideration of interpersonal difficulties and how they may relate to self concept.

Harter (1988) demonstrated that the importance placed upon specific self aspects has a profound impact on their influence on self esteem, in that children who were successful in self aspects they saw as important had high self esteem. This would seem to correspond with information processing theories that state that individuals form their own self aspects and use these to determine how old and new information about the self is processed. For example, using a card-sort methodology, Showers (1992) showed that these self aspects influence whether we see elements of ourselves positively or negatively and how important these particular aspects are. The author notes that this can be related to the psychological phenomenon of 'splitting', where individuals can see themselves in opposing ways; often described as the 'good me' and the 'bad me'. This has parallels with attachment literature and the work of

Bowlby (1980) who proposed that 'splitting' functions as a defence mechanism, assisting individuals who struggle to cope with negative experiences or negative information about the self by making negative aspects less accessible (as cited in Showers, 1992). Certainly, Herman (1992) notes that this strategy might also be related to dissociation, which, as noted earlier, can be experienced by survivors. Conversely, in depression, negative self constructs appear to be readily accessible as noted in Beck's (1967) model of depression, which is based on the premise of a triad of beliefs about the self as worthless, the world as meaningless and the future as pointless.

In CSA, Jehu (1989) suggested that characteristic distorted beliefs of survivors might be self-blaming beliefs about their earlier sexual abuse, commenting that this may involve a survivor attempting to make sense of her experiences by internalising feelings of badness and a perception that there was some particular characteristic or action of hers that resulted in her being abused. It can be argued that this would likely influence the processing of new self aspects. Certainly, Warner (2000) proposes:

> '*Children who have been sexually abused can sometimes end up believing that there are only two types of people: victims and abusers.' (Warner, 2000, p.60)*

The findings that women who have a history of CSA often become involved in further abusive relationships (Fleming *et al.,* 1999, Ferguson *et al.*, 1997) may be attributable to a survivor's perception of herself as powerless. It can be suggested

that because of the power differential in an abusive relationship, a prominent part of a survivor's sense of self is helplessness, which may foster an idea of herself as a victim, someone who is bullied or who has no control. Consequently, this may engender feelings of hopelessness and inevitability, resulting in a failure to protect oneself.

However, Warner (2000) states that it is important to note that this is not the case for all survivors and there are numerous ways in which a survivor's self concept may have been influenced by her abuse experiences. For example, for some women, the opposite is true, in that perceiving herself as being out of control means that regaining some control becomes an important issue. There are negative consequences for this though, as when someone is attempting to try and control everything, they may be perceived as being abusive towards others, physically, emotionally and/or sexually. It can be argued that this model of control has its origins in the behaviour of the abuser, which is internalised, so having power and being in control is linked with being abusive (Warner, 2000). Another way of attempting to gain control might be to focus on achievement because if she works hard, she can prevent bad things happening. However, the downfall of this strategy can be that because everything must be meticulously planned, any deviation from the plan can be extremely anxiety provoking. Similarly, other people being unreliable or inconsistent can cause an increase in anxiety. Therefore, not only does the survivor have to be perfect, so do others around her.

Perhaps these difficulties in self concept can be linked to the high incidence of borderline personality disorder within this population. Certainly, one of the defining characteristics of this diagnosis is problems in identity and self other boundaries. Given that Peleikis *et al.* (2004) note:

> *'...the more insecure an attachment is in childhood, the more distorted and unstable the view of self and others will be in adult life.' (Peleikis et al., 2004, p.62)*

it is understandable that a small disagreement or failing may cause the survivor to predict that an idealised other will be rejecting or become abusive. However, these sudden shifts in mood can be hard for the survivor and others to understand. Models of self concept have attempted to explain why such dramatic changes occur.

Taylor *et al.* (2007) suggest that structural aspects of the self-concept may be important; particularly, they argue that there may be an interaction between structure and content of self aspects. Two components have been discussed:

1. Compartmentalisation: the assignment of positive and negative traits to each self aspect i.e. to what extent self aspects are perceived as exclusively positive or negative.
2. Self-complexity: the extent to which traits appear in only one self aspect or recur over many.

These emerge from work by Showers (1992) and Linville (1985, 1987). Shower's (1992) model proposes that information about the self (self aspects) including roles (wife); moods (me when I am angry) and situations (me when I'm with my family) collectively form the self concept. As such, an integrated self-structure contains self aspects with both positive and negative traits whereas a compartmentalised self-structure contains self aspects that are polarised, i.e. they contain only positive or negative traits. In her later work, Showers (2000) suggests that this compartmentalisation may provoke extreme mood swings, in that, if a compartmentalised self aspect that is positively-biased is activated, this triggers all the positive traits in that self aspect, reinforcing positive self knowledge. On the other hand, if a self aspect that is negatively biased is activated, the individual will be flooded with negative traits and negative self-beliefs, without any positive traits within the self aspect to maintain a balance.

Linville (1985, 1987) on the other hand, suggested that an individual with a 'simple' self concept (i.e. simple in structure) might be at increased risk of distress as a result of characterising a number of self aspects in similar ways. Having fewer self-aspects and applying the same traits over a number of them, a negative trait would simultaneously be activated in several self-aspects. For example, if a situation triggered feelings of guilt in relation to one's role as a mother, this may also trigger guilty beliefs about one's behaviour as a wife and as a daughter, cumulatively creating overwhelming feelings of guilt. So, a particular self aspect may be activated as a consequence of being related to another self aspect that has just been activated.

However, consideration of an interaction between these two components: compartmentalisation and complexity, indicates that the picture may not be so straightforward. For example, a self concept with a simple structure and many highly positive self aspects predicts that affect would be consistently positive, given the lack of negative self aspects. Conversely, in a self concept with a simple structure but where self aspects were not compartmentalised, although self aspects with similar positive traits would be activated, they would be moderated by the presence of negative traits within the self aspects. Thus, Showers *et al.* (1998) suggest that an individual with a highly complex self-structure may also be at increased risk if negative content is high.

1.4.2 Investigating attributions relating to self and others

In order to investigate attributions about the self concept, repertory grids (Kelly, 1955; Ryle, 1979) have historically been used in the Cognitive Analytic Therapy (CAT) assessment process, to aid formulation. They are graphical representations of the individual's descriptions of their relational world. Creating repertory grids involves asking the client to identify aspects of themselves, roles or other people (elements) and then explain the relationships between these elements using adjectives or properties of each (constructs). Pollock (2001) describes how constructs are derived by picking three of the elements the client has identified and asking the client to choose a descriptor that would apply to two of the elements but not the third. He states that constructs are bipolar (for example happy-sad, mature-immature, optimistic-pessimistic) and that once a client has created a list of constructs they are asked to rate each element on a construct by employing a Likert scale e.g. from 1 –

not at all to 7 - extremely. Thus a matrix of scores is produced of how each element maps onto each construct. Principle components of factor analysis can then be used on the matrix grid. Pollock (2001) notes that the elements often chosen by survivors consist of parents, the perpetrator and a partner as significant people, victim, doormat and 'object' as roles they perceive that they inhabit and victim self, abusing self and ideal self are aspects of the self. He reports that consequently, constructs chosen by women with a history of CSA tend to include abusing-caring, trusting-betraying and controlling-accepting.

In contrast, Power *et al.* (2002) describe how Showers (1992) has developed an alternative model of self concept, which is accompanied by a useful way of assessing compartmentalisation. This is a self concept card sort test, as originally designed by Zajonc (1960) and developed by Linville (1985, 1987) to investigate variability of mood and individuals' responses to success and failure. It has been used mainly in unipolar depression, but more recently with individuals with bipolar disorder (Taylor *et al.*, 2007).

The card sort task involves participants picking from a selection of approximately 40 trait adjectives (e.g. insecure, energetic, loving) those that they feel are characteristic of the self aspects they would use to describe themselves (e.g. mother, single person, mental health service user). Participants can choose as many or as few self aspects as they wish and describe them using as many or as few trait adjectives as they wish (the same trait adjectives can be used to describe a number of self aspects). The list of trait adjectives includes equal numbers of positive and negative adjectives,

selected from commonly used adjectives generated by a student population and nine trait/mood adjectives that had been found to differentiate between depressed and non-depressed individuals. Participants were also asked to rate the self aspects for importance and perceived positivity and negativity on 7- point likert scales.

It can be suggested that this method of examining the self concept is similar to the use of repertory grids, but that the concepts selected are not restricted by bipolar constructs, rather single traits can be selected.

1.5 Interpersonal problems

1.5.1 Background

> *'Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love and community. They shatter the construction of self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience.' (Herman, 1992, p.51).*

As the previous section shows, intrapersonal difficulties can have an impact on interpersonal relationships, for example if one has a view of oneself as being a victim one might see others as being abusive. This quote highlights the substantive influence that a history of CSA can have upon a survivor's perception of relationships. The author notes that as a consequence of her damaged self concept, a survivor's understanding of the world is likely to be profoundly affected, and in turn will have an impact upon her relationships with others in a variety of contexts, not just those relationships from the past but also those of her future. Finkelhor and Browne's (1985) model attempts to explain this further by suggesting that because of

the betrayal involved in CSA, a child has a distorted impression of healthy, trusting relationships. The authors propose that consequently, a survivor is likely to encounter difficulties in intimate relationships, with marital problems and potential vulnerability to subsequent abuse, but also, in all probability, the betrayal will affect social relationships too. For example, they argue that survivors may avoid becoming involved in relationships because they have the expectation that they will be manipulated or otherwise harmed.

Jehu's (1988) University of Mannitoba study indicated that the main interpersonal problems are, in general: communication difficulties, assertiveness, anger control (due to difficulties with assertiveness skills) and trust and intimacy (which can be linked to poor self esteem or sexual difficulties). He suggested that these factors might leave survivors isolated and lacking social support and/or they may become locked in abusive and volatile relationships; as noted above, often women who have a history of CSA become re-victimised in later life. However, Finkelhor (1979) makes an interesting point that an elementary association between CSA and revictimisation may relate to their particular family situation in which the abuse occurs. It may be that any alternative is a means of escape, which may make a survivor more vulnerable to rape, domestic abuse or exploitation. Certainly Silbet and Pines (1981) report that in a survey of female prostitutes, 60% had a history of CSA. This is perhaps a reflection of having to deal with such difficulties.

In a review of interpersonal difficulties associated with CSA, Cahill *et al.* (1991) identified that the main issues were: problems with sexuality and relationship

problems, difficulties in social functioning and damaged emotional reactions and self-perceptions.

1.5.2 Relationships with men

Survivors report problems specifically in relationships with men, which is perhaps unsurprising given that, as noted above, the vast majority of abusers are men. Also, as described above, revictimisation is common in women with a history of CSA. For example Gorcey *et al.* (1986) reported that 37% of their sample of women who had been abused as children had subsequently been raped as a teenager or a young adult. This can be considered alongside an interesting study by Runtz (1987) who found that compared with 20% of women who had been physically abused, 44% of women who had been sexually abused as children had also been sexually abused in adolescence or young adulthood.

Consequently, often survivors are very wary and uncomfortable around men; indeed Jehu (1988) reported that 45% of women avoided long-term relationships with men. On the other hand Herman (1981) suggested that a possible alternative explanation for revictimisation was that some survivors idealised men and were attempting to recapture a feeling of specialness that they experienced with their abuser (particularly if the abuser was her father) as despite the abuse, this was an important attachment figure. Alternatively, some survivors may employ a different strategy of being promiscuous in an attempt to gain control over men.

Therefore, in a number of ways, it seems that relationships with men are likely to be complicated and a particular area of risk for survivors.

1.5.3 Relationships with partners

Relationships with partners can be difficult for a number of reasons. Survivors may become involved in relationships that are abusive as a result of low self esteem or feeling that they don't deserve any better (Meiselman, 1978). On the other hand, as noted above, they may have difficulties forming long-term relationships and women often report problems with intimacy and sexual relationships.

For example, Meiselman (1978) reported that 87% of survivors in his sample described themselves as promiscuous, frigid or feeling confused with regard to their sexual orientation. Also, Stein *et al.* (1988) found that 20% of the women in their study described experience of sexual dysfunction over the previous six months. When considering lifetime prevalence, they reported that 36% were frightened of sex, 32% had reduced sexual interest and 36% reported lowered experience of sexual pleasure. Alternatively, Gelinas (1983) reported that survivors could be over-compliant with partners, continually putting others' needs before her own, eventually giving rise to feelings of anger and resentment.

The degree of difficulty in relationships is demonstrated by Rhoades (1996) who found significant differences in interpersonal relationship satisfaction between women who had experienced intrafamilial abuse compared with women who had experienced extrafamilial abuse and women with no history of abuse, with women

with no history experiencing most satisfaction and women with intrafamilial abuse experiencing least satisfaction.

1.5.4 Relationships with family of origin

It is generally accepted that incestuous abuse by a father of stepfather is more traumatic than abuse by other family members or strangers (Browne & Finkelhor, 1986; Tsai *et al.*, 1979). Herman *et al.* (1986) found that the effects of father or step-father to daughter incest were more long-lasting. There are likely to be several reasons for this. Firstly, the scale of betrayal and loss of trust can be argued to be much greater when a parent abuses a child. This may also be indicative of a greater degree of family disturbance and consequently reduced availability of emotional support for the child. Furthermore, the frequency and duration of abuse may be greater. Finally, the consequences of disclosure may be conflict; the break up of the family or a child may be disbelieved. However, a basic requirement for survival is the presence of an attachment figure, therefore, despite these factors, a survivor has to find a way to remain attached to this person, which compounds difficulties (Briere, 2006).

Thus, Meiselman (1978) reported that relationships with mothers could also be a particular source of discontent. If a mother is disliked or blamed for allowing the abuse to occur, this relationship can be a serious source of stress, as very few daughters cut off ties with their mother, despite high levels of anger and tension. Ainscough and Toon (1998) explain this by suggesting that society's image of mothers is as a protector of children, but that when a child is sexually abused, the

system has failed to protect the child. Therefore, although it is less likely for a woman to sexually abuse children, mothers are often blamed for not preventing the abuse. Some mothers may find out that their child has been sexually abused and take the appropriate protective action. However, because of the nature of sexual abuse, mothers often do not know their child is being sexually abused. In some cases, mothers do not believe their daughters or may not feel able to cope and deal with the consequences.

Conte and Schuerman (1987) reported that the combination of the existence of supportive relationships and higher levels of family functioning accounted for the greatest degree of variance in measures of a child's functioning completed by both social workers and parents. In addition Peters (1988) found that the strongest predictor of long-term psychological difficulties was degree of maternal warmth.

1.5.5 Relationships with Children

Herman (1992) states that a survivor's overwhelming fear for her children is the repetition of a history of abuse. However, this can be played out in a number of ways. A mother may distance herself from her children and not be affectionate; for fear that she may be accused of being abusive. On the other hand, given that abuse rarely occurs in isolation within families and there tend to be other dysfunctional elements, a survivor may not have a good model of parenthood. Consequently, she may be overprotective of her children because of this sense of fear and because she may want to give her children everything that she feels she did not have, or she may create loose boundaries so that she has difficulty disciplining her children. She may

have problems with anger, which may affect her children (Jehu, 1988). It is not unrealistic to conclude, then, that a survivor's relationship with her children is unlikely to be easy.

1.5.6 Relationships with other women

Perhaps surprisingly, it can be suggested that relationships with other women can be very difficult. As indicated, women (often mothers) may be perceived as having failed the survivor by not noticing what was happening, or by failing to protect her. Therefore, women can be perceived as unreliable or untrustworthy, particularly as some women may have bullied other women, in a similar way to the re-victimisation by men. Also, gender roles may become distorted, for example, if a survivor's self esteem is low, there may be strong feelings of jealousy towards other women. Krause (2004) reports that female survivors may endorse negative stereotypes about women. This may be attributed to their perception of themselves as responsible for the abuse, being transferred onto the actions of other women who may be perceived as 'leading men on'. Other women may be seen as good or pure in comparison to themselves as 'bad'/dirty or other women may be seen as 'bad'/sluts. In addition, Herman (1981) reported that any anger survivors reported was towards women as opposed to men, with many feeling contemptuous about all women, including themselves. She notes that inevitably, this had a negative impact upon the survivors' social circle, making it difficult to develop supportive female friendships as women were seen as a threat, untrustworthy or inconsequential, with nothing to offer. However, upon further investigation, the author discovered that this dismissive attitude hid a powerful desire

for a caring female relationship, but most women survivors could not conceive of the possibility that this could exist.

Using Finkelhor and Browne's (1985) traumagenic dynamics model, Kallstom-Fuqua *et al.* (2004) attempt to explain this by suggesting that the experience of betrayal may result in survivors feeling suspicious of friends and that they are unable to confide in them. Similarly, the authors suggest that survivors may perceive intimacy with friends as being too risky or that others cannot be relied on, with the result that they are unable to discuss problems and receive feedback, thereby potentially limiting problem solving capabilities.

Nevertheless, although Jehu's (1988) report on the University of Manitoba study found that 49% of women in their sample were critical about women and 39% felt angry with other women, it is important to note that this only accounts for half of the women in this study, and the author reports that many of the women did report close friendships with other females.

1.5.7 Relationships in therapy

As has been demonstrated above, a core facet of the impact of CSA is a feeling of disconnection from others. Herman (1992) states that recovery therefore, involves empowerment of the survivor and the ability to create new connections with others. However, given the potential for difficulties in a variety of relationships, both familial and social, and the constellation of mental health problems that result, Chard (2005) states that survivors' sexual intimacy, communication, attachment and social

adjustment difficulties can have a marked impact on the therapeutic relationship. Llewelyn (2002) notes that a number of relationship challenges can be in evidence when working with CSA survivors, for example the experience of:

> *'...boundary violations, premature termination and divisions among teams of care or health workers, threats of and/or actual self harm and challenging counter transference reactions from therapists.' (Llewelyn, 2002, p.125)*

It can be suggested that given the history of betrayal discussed above, simply asking for help from services may be extremely difficult for survivors and the task of building a relationship of trust may be an enormous task. Perhaps in particular, the complex attributions made about other women that are discussed above may have particular implications for therapeutic relationships in that the majority of the therapeutic community is female. In addition, many services aim to bring survivors together to aid recovery. It is unlikely that general difficulties in interpersonal relationships will not have a part to play in such interventions.

1.6 Treatments for problems associated with CSA

1.6.1 Background

Numerous models have been developed to attempt to explain the impact of CSA. Each differs in the way it conceptualises the effects of trauma on the survivor and the therapeutic approach recommended or developed for treatment of the difficulties experienced. However, MacFarlane (1988, 1996) proposed that what traumatises adult survivors is not the event itself, but the representations of the event; the

memories or their perception of what the abuse meant to them. These are what affect the survivor's sense of self; the meaning they attribute to events and their perceptions of the world. For example, it can be suggested that a woman who experienced CSA in the context of a punitive or critical family background is likely to have a more negative self perception than a woman who had a loving and encouraging family to support her in dealing with such traumatic experiences. This is consistent with the previous discussion of interpersonal experience and self concept.

Thus, exploration of these representations and perceptions tend to be a central part of most therapy. Additionally, treatment delivery has varied not only in relation to the model employed, but also the format that is utilised, with many interventions involving group work with other survivors instead of, or as well as individual treatment. Two currently popular treatment models will now be discussed, the use of groups examined and comparisons made.

1.6.2. Individual therapy

1.6.2.1 Cognitive Behavioural models

Given the prevalence of mental health problems such as depression and low self esteem, Jehu (1988) devised a cognitive behavioural therapy (CBT) programme for women with a history of CSA, targeting what are labelled 'self-blaming' and 'self-loathing' beliefs and cognitive distortions that were considered to directly feed into symptoms and personality functioning.

Examples of distortions might be overgeneralisation (a belief that all men are abusive) or personalisation (a belief that it must have been something about 'them'

that led to them being abused). Self-blaming beliefs might include a perception that because the survivor did not tell anyone, they are to blame. Self-loathing beliefs may be related to feeling bad, dirty or inferior because of the history of CSA.

As with the traditional Beckian cognitive model (Beck, 1967), dysfunctional assumptions are identified, distortions recognised and therapist and client attempt to develop alternatives to challenge such beliefs. Also included in the intervention might be anger management, assertiveness, problem-solving and relationship enhancement techniques. Although Jehu's concepts are still employed in therapy, (Chard, 2005) notes that recent CBT research has focussed more on the treatment of PTSD symptomatology in women survivors, concentrating on the traumatic nature of the abuse.

Authors like McDonagh *et al.* (2005) noted that while the evidence base for individual CBT for other types of trauma is relatively strong, with numerous controlled trials, there was scant literature about control trials of PTSD symptomology in survivors of CSA. Chard (2005) suggested that this could perhaps be attributed to the substantive impact that CSA can have on a survivor's self concept and personality development, which make treatment more difficult. This may be due to the issues mentioned above (Briere, 2002) about the parallels between complex PTSD and borderline personality disorder.

Consequently, McDonagh *et al.* (2005) conducted a randomised controlled trial comparing individual CBT, present-centred therapy (based on a here and now

problem-solving approach) and a waiting list control group. The CBT intervention involved imaginal exposure, in vivo exposure and cognitive restructuring. The present-centred therapy intervention was chosen because it did not involve exposure work, as this was considered the main tenet of the CBT intervention, but was considered a potentially beneficial intervention for those with PTSD symptomatology who may find it beneficial to develop problem solving strategies. This was based on studies that found that problem solving approaches are efficacious in depression (Nezu, 1986; Nezu, 1987; Nezu & Perri, 1989). Results showed that both CBT and present-centred treatment were more effective than waiting list treatment in reducing PTSD symptom severity, levels of anxiety and trauma-related schemas. However, the treatment conditions made no greater impact on depressed mood, levels of anger, dissociation, or general quality of life. Also, the authors noted that a drop-out rate of more than 40% from the CBT condition suggested that many women were unwilling or unable to complete CBT treatment.

Although a number of possible contributory factors were considered, including differences between the therapists conducting the two different treatment interventions and the difficulties of clients in coping with prolonged exposure, complexity of clinical presentation may have been an important variable. Those who dropped out of the CBT intervention had higher levels of co-morbid symptoms (e.g. anxiety and depression) and all of the women who had been diagnosed with borderline personality disorder (4) as well as 7 (of a total of 11) women with a diagnosis of avoidant personality disorder dropped out of the CBT condition. By contrast there were no dropouts in the other two conditions, despite there being no

differences between the three groups in terms of the complexity of clinical presentation.

This is consistent with evidence from other studies (Tarrier, Pilgrim *et al.*, 1999; Tarrier, Sommerfield & Pilgrim, 1999) that individuals with a more complicated clinical picture may have more difficulties tolerating CBT treatment. In particular, the difficulties in affect-regulation and cognitive functioning that can be sequelae of CSA may introduce complications. For example, Chard (2005) notes that although recent interventions employing theory-based manuals that have been adapted from work done with rape survivors (e.g. Skills Training in Affect and Interpersonal Regulation/Prolonged Exposure, STAIR-PE; Cloitre *et al.*, 2002) have been relatively successful, she also highlights that some authors have experienced high dropout rates in such studies, even when they have included exercises to build coping skills. The author states that there is still work to be done in identifying models of treatment for CSA survivors that have high numbers of completers but that also produce clinically as well as statistically significant results.

The results of McDonagh *et al.'s* (2005) research suggests that given the favourable results regarding the present-centred therapy intervention, treatment that focuses on relationships and interpersonal functioning while teaching social problem solving skills may be a valid alternative. Thus, it can be suggested that perhaps Cognitive Analytic Therapy may have something to offer in this area given that it is a relational model.

1.6.2.2 Cognitive analytic therapy (CAT)

Although this therapy has a relatively short history (devised by Ryle, 1990, 1995, 1997) it is an established form of integrated psychotherapy, having been employed in a number of settings and with a range of client groups. In particular, it is considered a useful model for therapists working with women with a history of CSA (Pollock, 1996).

Llewelyn (2002) suggests that this can be attributed to the model's orientation as a brief, time-limited intervention with a broad theoretical background and consequently an array of therapeutic techniques. She further suggests that this is a particular asset when helping individuals deal with the impact of CSA given that CSA is not conceptualised as a diagnosis, but rather a selection of symptoms and behaviours that often cluster together, as has been indicated above. Consequently, CSA survivors can present with a range of difficulties that a therapist needs to be able to respond to in the most appropriate way.

The basic premise of CAT is that individuals have internal representations of relationships with themselves and others that become patterns played out in their everyday lives. These representations of relationships are described as 'reciprocal roles'; an example of a reciprocal role pair that may be found in survivors would be 'abuser-victim'. By working with the client to identify these internal representations (reciprocal roles) and associated self-defeating patterns of behaviour (for example, a survivor who is feeling victimised may avoid others, abuse alcohol or may 'turn the

tables' and become abusive) then the CAT therapist aims to aid the development of alternative intra- and interpersonal interactions (Ryle, 1990).

Key tools in this task are the reformulation letter and a diagrammatic representation of the formulation, the Sequential Diagrammatic Reformulation (SDR) or the Self State Diagrammatic Reformulation (SSDR). These are developed collaboratively with the client with two aims in mind. Firstly, developing self awareness and therefore aiding the containment of emotions and behaviours that are otherwise often chaotic and secondly, guiding change. This includes identification of how difficulties agreed as ones that the client wishes to tackle (described in CAT as target problems) may be understood as part of a system of experiencing, relating and behaving. Given the sense of helplessness and powerlessness often identified in women with a history of CSA, these tools are important aspects in the development of a renewed sense of control.

The CAT multiple self states model (Ryle, 1997) proposes that there are three levels at which an individual can have difficulties. The first involves the content of the reciprocal roles. For example, as suggested above, an individual with experience of abuse may have an internal representation of relationships as involving one person abusing the other (producing an abuser-victim reciprocal role pair).

The second level of disturbance is where an individual has a number of different reciprocal role pairs (each pair known as a self state) that are not 'integrated', so that the individual has a very different sense of self and others when in different self

states. Often these different self states are quite polarised. Thus, for example, an individual may have a self state involving abuser-victim and a self state involving rescuer-rescued.

The third level of disturbance concerns an individual's awareness of movement between different self states. Ryle (1997) conceptualises this lack of integration between different self states as borderline personality structure.

As a result of its short history, the body of outcome data for CAT is not large. Pollock (2001) argues that in view of it being in the early stages of development, novel practice and case series studies should precede formal evaluation (i.e. randomised controlled trials (RCTs)) as the focus should be to extend the theory and practice of CAT. Consequently, he reports on a case series of 37 survivors (31 of whom were female) treated using CAT, who were outpatients, or inpatients of a psychiatric hospital, prison or medium secure unit. All clients competed 16-24 individual sessions of CAT (no one dropped out of therapy), with almost half receiving additional treatment involving Eye Movement Desensitising and Reprocessing (EMDR) or completing Imagery Rescripting and Reprocessing (IRR). Measures used were: Millon Clinical Multiaxial Inventory-3 (MCMI-3; Millon *et al.*, 1994), Symptom Checklist-90-Revised (SL-R-90; Derogatis, 1983), Dissociation Questionnaire (DIS-Q; Vanderlinden *et al.*, 1993) and the Post-Traumatic Stress Disorder-Interview (PTSD-I; Watson *et al.*, 1991). These were administered pre- and post treatment, and at three, six and nine months follow up.

Analysis of the results showed statistically significant decreases on the MCMI-3 personality dimension scores for the avoidant, depressive, dependent, self-defeating and borderline scales, as well as in ratings of dissociation (DIS-Q), re-experiencing, intrusive and avoidant symptoms scales on the PTSD-I and on all symptom scales of the SCL-R-90. Improvements were shown in the recognition and revision of target problems, (described earlier) with consolidation at three month follow up and self injury and suicide attempts reduced over the follow up period. Wildgoose *et al.* (2001) described a case series involving five individuals with a diagnosis of BPD, (four of whom had a history of CSA) who had completed a course of 16 weekly sessions of CAT. Following therapy, two clients no longer met the DSM-IV criteria for BPD, and all clients were below caseness at nine month follow up.

Although Pollock (2001) acknowledges that this cannot be argued to represent a sufficient evidence base for the efficacy of CAT, he argues that these preliminary studies suggest that we might be optimistic about the application of the model.

Given the reported prevalence of personality disorder, interpersonal problems and self-defeating patterns of behaviour (discussed earlier) in this client group, CAT therefore seems highly relevant to those working in the area, in particular, because special attention is paid to the way in which these reciprocal roles are played out within the therapy setting.

1.6.3 Group therapy

Lau and Kristensen (2007) state that rather than individual work, the treatment of choice for CSA is homogeneous therapy groups. They argue that this has proved an effective intervention for the reduction of psychiatric symptoms in this population through the opportunity of self disclosure and a sense of cohesion within groups. However, Ryan *et al.* (2005) note that there is scant empirical evidence regarding the treatment of CSA survivors and that although many authors have indicated benefits of group therapy often there is no comparison group or long-term follow up.

Also, Kessler *et al.'s* (2003) critique of 13 outcome research studies suggested that methodological weaknesses in the analysis of such groups reduce the empirical validity of such work. In addition, WHO (2002) state that few studies have evaluated interventions for adult survivors of CSA and that of those that have, most have concentrated on intrafamilial abuse between girls and their fathers.

From a CBT perspective, Chard (2005) states that the recent focus has been on individual interventions as some have considered that group work that involves hearing the histories of other survivors introduces the risk of secondary traumatisation. However, she argues:

> *Although individual therapy can provide ample opportunity for processing and challenging cognitions, it cannot provide the same normalising, universalising and useful social dynamics as group therapy. (Chard, 2005, p966)*

de Jong and Gorey (1996) see the benefits of group therapy as reducing client dependence, encouraging a commitment from participants by focusing on their strengths and creating boundaries and structure that may have been lacking within their family life.

Peleikis and Dahl (2005) note that group treatments have been almost exclusively based on Courois's (1988) conclusions about the consequences of CSA, covering retraumatisation, sexual difficulties and interpersonal problems, negative self-concept, emotional consequences (e.g. anxiety and depression) and physical complaints. The authors note that goals of treatment are generally focussed on acknowledging personal history of CSA but placing responsibility with the perpetrator, increasing trust, identifying helpful coping strategies to replace unhelpful survival strategies, dealing with difficult talks of mothering, improving self concept and reducing social isolation.

In support of this, although a systematic review of the CSA literature conducted by Peleikis and Dahl (2005) reported finding just 24 empirical treatment studies of groups and only 13 of these included control groups, the review did indicate that there was moderate gain from psychotherapeutic intervention with adult female survivors of CSA in comparison to wait list controls, which is maintained at follow-up. Nonetheless the authors intimate that the political context of these studies should be borne in mind, noting that since CSA is largely inflicted upon females, research has often been driven by Northern American feminist movements, and so perhaps

relate to a particular culture at a particular point in history. The authors make interesting comment about the 'partisan flavour' of many of these studies:

> *'CSA is [presented as] very special trauma, in need of engaged female therapists, offering group therapies based on incest resolution carried out in special settings focussed on CSA.' (Peleikis & Dahl, 2005, p310)*

This is certainly a common theme within the literature, that therapists working with survivors tend to be women, yet there is rarely any explanation as to why it is assumed that this is the best treatment approach. In a review of group interventions Peleikis and Dahl (2005) found that only one study made reference to the mixed gender of group leaders. Threadcraft and Wilcoxon (1993) found that having both a male and a female therapist in group treatment was well accepted by participants.

Similarly, as mentioned earlier, Lau and Kristensen (2007) assert that homogeneous groups are the treatment of choice for survivors. Given the research discussed about survivors' fear of men, this is perhaps an important consideration, but by the same account, attributions and experiences of other women are likely to have an impact on group processes too. Certainly, Fisher *et al.* (1993) investigated dropout rates in group psychotherapy. One of the significant differences between completers and those who dropped out of therapy was that personality test results for the latter group showed lower levels of trust and increased levels of anger. It can be suggested that perhaps those who struggle more with interpersonal relationships are more likely to experience difficulties in a group therapy context, consequently finding it harder to complete treatment, and therefore not receiving appropriate care, reinforcing

negative self concepts in the process. Hazzard *et al.*'s (1993) study lends potential support to these findings, as women who had a history of psychiatric hospitalisation were more likely to drop out of therapy. Also Cloitre and Koenen (2001) found a negative effect on outcome in groups that included women with borderline personality disorders. Given that a main tenet of BPD is the experience of difficulties in interpersonal relationships, this indicates that there are important relationship processes occurring in groups that need to be acknowledged, even in the context of psychoeducational groups.

In summary, it seems that while there are potential benefits from groups for female survivors of CSA there also appear to be potential difficulties, or at least issues that it would be useful to address. Thus, as in individual therapy there must be an awareness of the interpersonal difficulties that survivors may experience in working with other women.

Consequently, some clinicians have explored the use of combined group and individual psychotherapy. Peleikis and Dahl's (2005) systematic review of the CSA literature found that in a third of the studies reviewed, participants in group treatment also received individual psychotherapy. Twenty-five percent of studies did not allow concurrent treatment and 42% of studies did not refer to the presence of absence of individual therapy in addition to group psychotherapy.

Chard (2005) suggests that by combining group and individual therapy this may have a positive impact on dropout rates. She proposes that this would allow a survivor

some individual time to process her own personal experiences, combined with the opportunity of group work with other survivors and the feelings of cohesion, universalising and normalising that can come with this. She emphasises the opportunity provided in individual therapy for building a therapeutic relationship with one of the group leaders.

1.7 Summary

This review of the literature indicates that women with a history of CSA are at increased risk of experiencing a range of mental health, interpersonal and intrapersonal difficulties. As indicated, there is no diagnosis of 'survivor abuse' (although some would use the term complex PTSD). However, as noted, while not ignoring the other potential effects of a survivor's physical health problems, this client group do account for a significant number of individuals using mental health services; often repeatedly. Consequently, services must strive to provide the most effective and efficient therapeutic interventions for these individuals. However, negative self concept and interpersonal difficulties experienced in everyday life are often brought into the therapeutic environment, bringing with them their own challenges. Women's views about other women is therefore considered to be an important area of study in its own right, and could provide valuable information, which could help in the development and maintenance of the therapeutic relationship. Further, as treatment may also involve group work with other women, it seems imperative that this issue is better understood.

1.8 Aims

Drawing from CAT and selfconcept literature discussed earlier, as well as the literature on CSA, it seems possible that women with a history of CSA may have particular ways of perceiving themselves as a women or specific perceptions of other women, which, as well as impacting upon relationships within their everyday lives, may also have implications for therapy, whether this is on an individual basis or within a group. The possible nature of these difficulties, along with examples of the implications of each is described below.

1 Women who have a history of CSA may have a negative self-concept but their attributions about other women may be positive.

It might be argued that this may be assumed in therapy. For example, if employing a CBT model and challenging negative thoughts, a therapist may ask a survivor to compare her beliefs about herself to the attributions she might make about another woman in a similar situation, with the expectation that this might help her become aware of how she judges herself differently and lead her to challenge this.

2 A second possibility of how women with a history of CSA may perceive themselves and other women may involve them having a negative self concept and making negative attributions about other women, this perhaps being based on their past experience of other women (such as experiencing their mother as weak) or a generalisation of their view of themselves

An implication of this for a woman in group treatment might be that a survivor is critical of other women within a group and may not value what they have to offer.

3 A third consideration is that women who have a history of CSA may have polarised views of themselves and other women. Some women may be seen as having only positive attributes whilst others have only negative attributes (for example seeing some women as pure and other women as bad/dirty). Or possibly other women may inhabit both of these roles at different times or in different situations (e.g. Ryle, 1990).

An implication for individual treatment would be that the therapist's position might be perceived to oscillate between being an ally and an enemy. In group treatment this may result in splits occurring between group members leaving some individuals feeling isolated or criticised.

This study will attempt to investigate the first two ideas by replicating Shower's (1992) card sort methodology, which is based on her model of the self concept. This method has been chosen in preference to the use of repertory grids, as it does not restrict the traits to bipolar constructs. In addition to the adjectives identified by Showers (1992), some trait adjectives will be added that are considered to be representative of characteristics that survivors may attribute to themselves and others, based on clinical experience working with survivors and the elements and constructs discussed by Pollock (2001).

Given that studies indicate that depression is one of the most common mental health problems experienced by women and evidence suggests that history of CSA may be a direct contributor to depressed mood, a comparison group of women who were depressed but who did not have a history of CSA is included as well as a healthy non-clinical comparison group recruited from hospital staff. Furthermore, the subsidiary hypotheses are designed to investigate compartmentalisation in women with a history of CSA. It is expected that as well as having a general negative self concept, individual self aspects will also be perceived negatively.

1.9 Hypotheses

1.9.1 Main Hypotheses

1.9.1.1 Hypothesis 1 – Self concept

a. Women who have a history of CSA and women who are depressed will attribute fewer positive and more negative words to themselves relative to a non-clinical sample.

b. The groups will be further differentiated in that women who have a history of childhood sexual abuse will attribute more CSA words (defined in section 2.4.1) to themselves than the other two groups.

1.9.1.2 Hypothesis 2 – Other women

a. Women who have a history of sexual abuse will attribute more negative words and fewer positive words to other women relative to women who are depressed and a non-clinical sample.

b. These negative characteristics will differ between groups in that the CSA group will attribute more CSA words to other women than the other two groups.

1.9.2 Subsidiary hypotheses

Subsidiary hypothesis 1) i.

The CSA and Depression groups will attribute fewer positive words and more negative words to specific self aspects than the non-clinical group.

Subsidiary hypothesis 1) ii.

These negative attributions will differ between groups in that the CSA group will attribute more CSA words to specific self aspects that the other two groups.

2. Method

Three groups of participants used an adapted version of the card-sort test (Showers, 1992) allowing aspects of self concept and attributions about other women to be investigated. Questionnaires were also completed to establish trauma sequelae, self esteem, levels of personality integration and depressed mood.

2.1 Design

A mixed design was used to investigate the self concept and attributions made about other women within three groups: women with a history of sexual abuse, women who are depressed and a non-clinical group of hospital workers. A between-subjects design was used but correlational analyses were also conducted.

2.1.1 Power Calculation

Very little research has been conducted in this specific area of women's attributions about other women. However, a number of previous studies have utilised the self-concept card sort test. Consequently, Cohen's (1992) formula for calculating effect size (for tests of difference) could be employed, on the basis of a large effect size, which would be predicted by previous research articles of a similar nature (e.g. Power, *et al.,* 2002; Showers, 1992; Taylor *et al.*, 2007).

Therefore, based on Cohen's (1992) estimate of sample size (setting power at 0.8 and alpha at 0.05) one-tailed between subjects tests of difference would require that N=20 (Clark-Carter, 2004).

2.2 Ethics

2.2.1 Ethical Approval

Ethical approval was granted by the Lothian Research Ethics Committee (appendix 7.1).

2.2.2 Ethical Considerations

Adhering to the British Psychological Society (BPS) Good Practice Guidelines for the Conduct of Psychological Research within the NHS, (Cooper *et al.*, 1993) appropriate steps were taken to ensure that the study was ethical and did not cause harm.

2.2.3 Recruitment considerations

Individuals in the clinical groups were invited to participate in the study following an assessment appointment, or during the course of treatment, by their clinical psychologist, Beyond Sexual Abuse (BSA) group leader or Overcoming Depression group leader (appendix 7.2). Professionals were requested to send a reminder letter (appendix 7.3) to individuals if they had not contacted the researcher within one week of being asked to participate, in case the initial letter had been lost or mislaid. However, the researcher did not make contact with any potential participants until an

opt-in form had been returned or an individual had contacted the researcher by telephone. This process was designed to minimise any perceived pressure to participate.

Those in the healthy non-clinical comparison group responded to a poster or email request (appendix 7.4) for volunteers and so were under no pressure to participate.

2.2.4 Considerations regarding consent

Individuals were provided with detailed information sheets (appendix 7.5) and also given several opportunities to ask questions, in order that they could make an informed decision as to whether or not to fully consent to the research.

The General Practitioners (GPs) of all participants were notified by letter (appendix 7.6) and given the chance to contact the department if they had any queries about an individual's participation.

2.2.5 Testing considerations

For those in the clinical groups, research sessions were arranged at times when the participant's psychologist, group leader or the clinical supervisor of the project was available. In this way, should any participant become extremely distressed, they could be given the option of speaking to another professional about their participation in the research.

Prior to the commencement of the test procedure, the format of the session was fully explained to participants and the tasks involved were outlined in detail. Given the potential vulnerability of some of these participants, there was a possibility that power differentials might characterize the relationship between participants and the researcher. As such, participants were given the opportunity to have a break in the session at any point and were made aware that they could withdraw from the study at any time. They were reminded of this option throughout and in cases where more time was required; they were given the option of continuing or returning for a second appointment.

The researcher encouraged participants throughout the testing procedure to complete the tasks at their own pace. If particular issues arose while the participant was completing the tasks, it was reiterated that everything discussed as part of the research was confidential unless the researcher was concerned about harm to the participant or another individual, but that perhaps the participant may want to discuss the issue in more detail with her psychologist or group leader.

Just as levels of distress were monitored throughout the research session, participants were asked to reflect on the process of having completed the tasks once all aspects were finished. Anyone who seemed distressed was given the option of speaking to another professional at the time or was given the option of contacting the Psychology Department later in the day or having another professional contact them. Those in the non-clinical comparison group were given a letter with contact numbers and

advised to speak to the researcher's clinical supervisor, the Head of the Psychology Department or their general practitioner, should they find themselves in distress (appendix 7.7).

All participants were thanked for their participation, and were asked if they wished to receive a summary of the completed study's findings. The participants were informed that all data would be anonymised and confidentiality protected.

2.3 Participants

2.3.1 Overview

Three groups participated in this study, a group of individuals with a history of childhood sexual abuse (N=20), a comparison group of women who were currently depressed (N=16) and a non-clinical comparison group of hospital staff (N= 34). The groups were approximately matched for gender, age and marital status.

Childhood Sexual Abuse (CSA) Group

The participants in the experimental group consisted of female clients currently engaged in treatment provided by the Adult Clinical Psychology Service at St Johns Hospital in Livingston, West Lothian. Their primary difficulty had been established as dealing with the effects of a history of childhood sexual abuse.

Comparison Group 1 – Depression

Participants in this group were current clients of Adult Clinical Psychology Service at St Johns Hospital in Livingston, West Lothian whose primary problem was depressed mood.

Comparison Group 2 (healthy, non-clinical) – Hospital Staff

Participants in the healthy non-clinical comparison group were recruited from the staff at St Johns Hospital in Livingston. They did not have a history of trauma and were not currently depressed.

2.3.2 Inclusion Criteria

To be included in the study, participants had to meet the following criteria:

CSA group:

1. Female
2. Primary problem identified as dealing with the impact of childhood sexual abuse.

Depression group:

1. Female
2. Primary problem identified as depressed mood.

Non-clinical comparison group:

1. Female
2. Staff member at St Johns Hospital
3. No history of trauma
4. Not currently depressed

2.3.3 Exclusion Criteria

1. Women who were experiencing positive symptoms of psychosis.
2. Women who were abusing alcohol or illegal drugs.
3. Women who were detained under Mental Health Act Legislation.
4. Women who had been sexually abused by women.
5. (in the non-clinical comparison group) women who scored above cut-off on measures of depression or trauma.

2.3.4 Recruitment

CSA Group

Individuals were verbally invited to participate in the study by their clinical psychologist or a member of the psychology or nursing staff involved in facilitating 'Beyond Sexual Abuse' (BSA) groups within the Psychology Department. These professionals had previously been provided with an outline of the study and guidance on recruitment criteria (appendix 7.8).

Staff were asked to give potential participants a research pack that contained a letter inviting them to participate, (appendix 7.2) an information sheet explaining what the study involved (appendix 7.5) and a prepaid envelope with the Psychology Department address on it. A tear-off slip was included at the end of the information sheet and potential participants were asked to opt-in to the study by either returning the tear-off slip in the envelope provided or telephoning the Psychology Department on the number provided. Individuals were asked to opt-in to the study within 7 days. If they had not opted-in within this time period, the staff member who was involved

in their care then sent a reminder letter in case the information had been mislaid (appendix 7.3). If an individual had opted in to the study the researcher contacted them and arrangements were made to meet for a research session. Consent forms (appendix 7.9) were completed at the start of the session.

Depression Group

The matching requirements of the comparison groups were established after identifying participants in the CSA group. Sector clinical psychologists and a Clinical Associate in Applied Psychology (Primary Care) who was involved in facilitating a group treatment for depression, identified suitable participants for the depression group. As with the experimental group, staff were asked to give potential participants a research pack that contained a letter inviting them to participate, (appendix 7.2) an information sheet explaining what the study involved, (appendix 7.6) and a prepaid envelope with the Psychology Department address on it. The procedure for opting in to the study was as for the CSA group (see appendix 7.3 and 7.9 for copies of the reminder letter and the consent form).

Non-clinical comparison group

Posters (appendix 7.4.1) were displayed in various places within St Johns Hospital, and an email was sent using the staff notice board facility (appendix 7.4.2). These invited female staff members who would be willing to participate in a psychology department research study to contact the researcher. The email and poster advised that potential volunteers should not have experienced any traumatic life events.

Any notes of interest were followed up by sending a similar research pack to those received by the other two groups. (See appendices 7.2, 7.5, 7.3 and 7.9 for copies of the invitation letter, information sheet, reminder letter and consent form).

2.3.5 Response Rate

Clinicians were asked to keep a record of those clients who were asked to participate in the research, but who declined to take part.

CSA group

Of the 29 clients invited to take part in the study, 20 opted in, a response rate of 68.9%. Of those who opted-in, no participants were excluded.

Depression group

Of the 23 women invited to take part in the study, 16 opted in, a response rate of 69.6%. All of those who opted in were included in the study.

Non-clinical comparison group

Of the 42 staff members who expressed an interest, 4 did not respond within the time frame and so were not included and 4 did not opt-in to the study. This is a response rate of 81%. Consequently, 34 participants were included in the non-clinical comparison group.

2.4 Description and Application of Measures

The following section describes the materials used to measure each variable and the manner in which these were applied.

All participants were asked a number of demographic questions prior to commencing the study (appendix 7.10). Women with a history of childhood sexual abuse were also asked brief questions about their history of abuse, for example the age at which it began and the relationship of the perpetrator to them, to allow the characteristics of the population to be established (appendix 7.11).

2.4.1 Self concept and attributions about other women

The method of the self-concept card sort task used by Showers (1992) was employed and further developed. A few amendments were made to the set of trait adjectives used and 10 additional adjectives were included as adjectives that, from clinical judgement and a review of the literature (Ellington & Marshall, 1997), were perceived to be pertinent for women with a history of CSA (appendix 7.12). Participants were asked to use as few or as many of the set of trait adjectives to:

i. describe themselves in general

ii. describe other individual women who had played a part in their lives

iii. describe as few or as many self-aspects as they perceived described themselves (i.e. mother, neighbour, colleague etc.)

In addition, in each of the three exercises above, participants were encouraged to note any supplementary trait adjectives they attributed to themselves or others. Finally, participants rated each of the other women and self aspects on 7-point Likert scales measuring importance and perceived positivity or negativity.

2.4.2 Trauma sequelae

Trauma sequelae were measured using the Trauma Symptom Inventory (TSI) (Briere, 1995) (appendix 7.13). This 100-item questionnaire of post traumatic stress and other consequences of traumatic events is an established measure of trauma sequelae and appropriate versions are currently used in NHS Lothian Adult and Child Psychology services. It is a particularly useful measure for assessing trauma in the context of childhood sexual abuse as it assesses the intrapersonal and interpersonal difficulties that are often a consequence of long-term psychological trauma as well as post traumatic stress.

The TSI consists of 10 clinical scales and 3 internal validity scales. The clinical scales are: anxious arousal, depression, anger/irritability, intrusive experiences, defensive avoidance, dissociation, sexual concern, dysfunctional sexual behaviour, impaired self reliance and tension-reduction behaviour. Items are rated on the basis of frequency of occurrence over the previous 6-month period using a four-point scale from 0 (never) to 3 (often). Higher scores are interpreted as suggestive of greater symptomatology.

Briere (1995) found that the 10 clinical scales showed internal consistency in standardization (N = 836) (mean α = .86), clinical (370) (mean α = .87) university (N = 279) (α = .84) and military (N = 3659) (α = .85) samples. Results also indicated that the 10 scales exhibit reasonable convergent, predictive and incremental validity. Good criterion validity was shown in two ways. Firstly, in a subset of the standardization sample (n=449), PTSD status (as established by other measures) was correctly predicted in over 90% of cases. Secondly, in a psychiatric inpatient sample (N = 105) Borderline Personality Disorder (as per Diagnostic and Statistical Manual of Mental Disorders 3rd edition revised (DSM III-R)) (APA, 1987) criteria was correctly identified using the TSI scales in 89% of those diagnosed independently (Briere, 1995).

Due to the length of this questionnaire, if a participant had recently completed it as part of the assessment process with a clinician, they were not asked to complete it again. Instead, a copy of the completed questionnaire was obtained from the staff member who had conducted the assessment.

2.4.3 Global self-esteem

Global self evaluation was measured using the Rosenberg Self Esteem Scale (Rosenberg, 1989) (appendix 7.14). This is a brief 10-item paper and pencil questionnaire, requiring participants are to rate on a four-point likert scale, to what extent they agree or disagree with positive and negative statements about the self. A high score indicates high self esteem. The scale was initially developed for use with adolescents but its application has been broadened and it is widely used as a measure

of self-esteem. Reasonable internal consistency has been demonstrated (α =.77) and test-retest reliability is good, ranging from r =.85 to r =.88 (Shisslak *et al.*,1999). Extensive validity (convergent and discriminant) results have been demonstrated (Blascovich & Tomaka, 1991).

2.4.4 Level of personality integration

The Personality Structure Questionnaire (PSQ) (Pollok *et al.*, 2001) (appendix 7.15) is based on the CAT Multiple Self States Model of borderline personality disorder (BPD) (Ryle, 1997) and aims to investigate individuals' level of integration; a lack of integration being associated with having distinct self states. Ryle (2004) reports that given self state instability is common in cluster B personality disorders and can be difficult to manage, the PSQ facilitates discussion of self states and state switches, presenting the opportunity for management of these difficulties and personality integration.

It is an 8-item paper and pencil questionnaire. Items are scored 1-5 and yield overall scores between 8 and 40. Ryle (2004) outlines the results of clinical and non-clinical samples where the mean scores of patients diagnosed with BPD were over 30 and mean scores of non-clinical samples were between 19.7 and 23.2. Pollock *et al.* (2001) report reliability of α = .59 for all 8 items, with item 7 removed α = 0.78 in a general population sample. In a clinical sample of psychotherapy patients an alpha coefficient of .77 was obtained and in a BPD sample a coefficient of .87 was found. Test-retest reliability was r = .75. Convergent and discriminant validity are relatively good.

2.4.5 Depression

The Beck Depression Inventory Second Edition (BDI-II) (Beck *et al.,* 1996) (appendix 7.16) was used as a formal measure of assessing depressive symptomatology in all three groups.

The BDI-II was developed to correspond with criteria for a diagnosis of depression according to the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV, APA, 1994). This self-report questionnaire has 21 items and is designed for use with adults and adolescents of 13 years and above. Items are rated on a four-point scale (0-3), total scores range between 0 and 63. Research studies (e.g. Poole *et al.*, 2006) advocate a cut-off score of 17 for clinical depression.

The authors reported high internal consistency ($\alpha = .93$) among 120 college students, and among 500 outpatients ($\alpha = .92$). Excellent test-retest reliability was indicated ($r = .93$, $p<0.001$) based on a small sample of outpatients ($N = 26$) and corrected item-total correlations were significant ($p<0.05$). In the outpatient group, these ranged from .39 on the item 'loss of interest in sex' to .70 on the item 'loss of pleasure'. The range for the college student sample was similar: .27 (loss of interest in sex) to .74 (self dislike). The scale has been validated with many populations from adult psychiatric outpatients (Ball & Steer, 2003) and inpatients (Cole *et al.*, 2003) to substance abusers (Buckley *et al.,* (2001) and patients with chronic pain (Poole *et al.*, 2006).

Grothe *et al.* (2005) and Dozois *et al.* (1998) demonstrated good convergent validity with the BDI and Steer *et al.* (1997) showed good discriminant validity in that the BDI-II showed weaker relationships with measures of anxiety.

2.5 Procedure

Other than asking the CSA group some brief questions about their history of abuse, there were no differences in the procedure for the three groups. All participants were tested on a one-to-one basis, in an individual clinical psychology clinic room. In general, participants were seen for a single session, although 3 participants required more time and so returned for a further appointment. In order to ensure consistency of the testing procedure, the same researcher assessed all participants.

Participants completed the aforementioned measures in the order presented below:

a) Demographic information

b) (CSA group) Information about history of abuse

c) General Self Aspect

d) Attributions about other women

e) Trauma Symptom Inventory (TSI)

f) Rosenberg Self-esteem Inventory

g) Personality Structure Questionnaire (PSQ)

h) Beck Depression Inventory Second Edition (BDI-II)

Participants were advised that the research session would take approximately 1 hour. However, this varied between 30 minutes and 2 hours according to the number of women, roles and attributions chosen.

Before commencing each of the measures, all participants received verbal task instructions and the researcher clarified the participant's understanding before proceeding. All participants were informed that they could discontinue at any time. (appendix 7.17)

2.6 Data analysis

All results of the card sorts and questionnaires were subsequently recorded on an SPSS database and statistically analysed using SPSS (Statistical Package for the Social Sciences) for Windows, Version 14.

2.6.1 Varying number of self aspects and other women discussed

Each individual participant varied in the number of self-aspects and other women she chose to describe using the card sort test. Thus, initially, each of the self-aspects and other women were compared over groups in the order in which they were discussed. Subsequently, the most common self aspects and other women discussed were extracted from the data and compared over groups.

2.6.2 Varying number of adjectives

The particular adjectives chosen and number of adjectives employed to describe general self concept, individual self aspects and individual other women varied dramatically across individuals. Consequently, it was decided to total the number of positive, negative and CSA words for each aspect or person described. The mean number for each was then compared over the three groups, using one-way Analysis of Variance (ANOVA).

3. Results

Descriptive statistics are outlined initially, including demographic information about all of the participants, mean questionnaire scores, information about the history of abuse of the CSA group and a description of exploratory data analysis. The second part of the results section details how each hypothesis was tested individually using inferential statistics.

3.1 Exploratory data analysis

Marital status data were complicated with many different living circumstances being described. Consequently, data were collapsed into 2 categories, 'married' (including 'married', 'co-habiting' and 'previously married but co-habiting with a new partner') and 'not married' (which included 'single', 'divorced', 'separated', 'widowed', 'boyfriend' and 'previously married but with a new boyfriend') for ease of analysis. Similarly, complicated employment status data were collapsed for ease of analysis into 'employed' ('full-time' and 'part-time') and 'unemployed' ('unemployed', 'housewife and mother', 'student', 'volunteer' and 'retired') categories.

3.2 Descriptive Statistics

3.2.1 Participant Demographics

CSA group

Twenty participants with a history of CSA took part in the research. All were female and ranged in age from 32 years to 52 years (mean age = 42.15, SD = 5.92). Fifteen women were married (or living with their current partner) and 5 women were not

married or living with a partner. Sixteen participants had a least one child and 4 did not have any children. Employment status was also examined. Twelve women were employed, 8 women were not.

Depression group

Participants in the depression group were approximately matched with those in the CSA group in terms of gender, age and marital status. Sixteen women participated, aged between 23 and 57 years (mean age = 42.75, SD = 10.82). Ten women were married or living with their current partner and 6 women were not married or living with a partner. Twelve women had at least one child and 4 did not have any children. Employment status was also examined. Six women were employed, 10 women were not.

Healthy non-clinical comparison group

Thirty-four volunteers were recruited to the control group. They were matched approximately with those in the CSA group in terms of gender, age and marital status. Age ranged between 24 years and 59 years (mean age = 42.81, SD = 8.40). There were 26 women in the married category and 8 women in the not married category. Twenty-eight participants had at least one child and 6 did not have any children. Employment status was also examined. All 34 women were employed.

Using a one-way analysis of variance (ANOVA), and *post-hoc* Scheffé tests, the three groups were compared statistically on age. No significant differences were detected. Chi-squares showed there was no significant difference between the marital

status of the three groups or status as a mother. However, there was a significant difference in employment status between the three groups (χ^2 (2, N = 70) = 0.52, $p<0.001$) but given that the non-clinical group was a convenience sample, this is to be expected. Consequently, this group was removed from the analysis and a chi square was performed on the data of the two clinical groups. This did not show a significant difference between groups (χ^2 (1,N=36) =0.22, p=NS), therefore it was considered that subsequent covariant analysis was not required to control for employment status (appendix 7.18).

Table 1 shows a summary of the results of the tests of difference/association, for the three groups.

Table 1: Descriptive characteristics of the sample

	CSA Group (n=20) X (SD) Range	Depression Group (n=16) X (SD) Range	Non-clinical Group (n=34) X (SD) Range	Test of difference / association	P
Age	42.15 (5.92) 32-52 years	42.75 (10.82) 23-57 years	43.24 (8.59) 24-59 years	F (2,67) = 0.10	0.90 NS
Marital status	15:5	10:6	26:8	$\chi^2 = 0.13$	0.57 NS
Has children	16:4	12:4	28:6	$\chi^2 = 0.72$	0.83 NS
Employment status	8:12	10:6	0:34	$\chi^2 = 0.52$	<.001

3.2.2 Questionnaires

Scores on the four questionnaires were compared between groups to ensure that the healthy non-clinical group did not indicate experience of trauma sequelae, depressive

symptoms, low self-esteem or significant levels of lack of integration (as described in the multiple self states model).

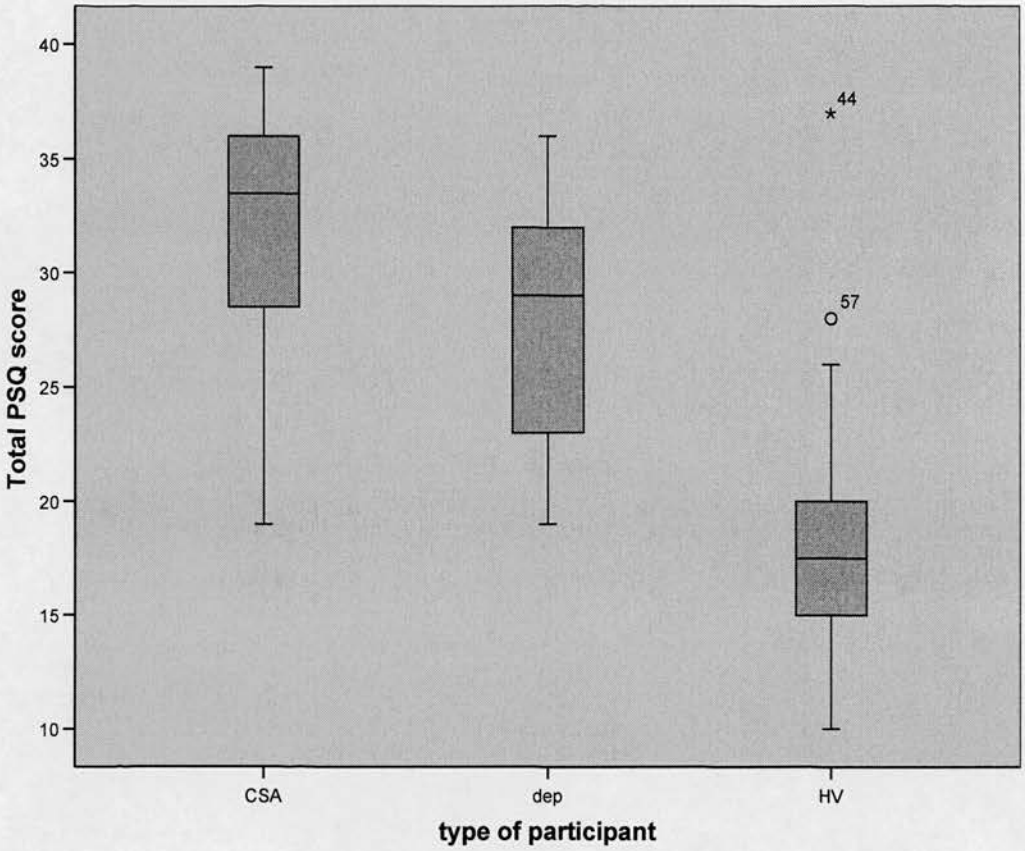
3.2.2.1 Personality Structure Questionnaire (PSQ)

One way ANOVA indicated there was a significant main effect of group ($F(2,67)=44.80$, $p<.001$). *Post-hoc* Scheffé tests revealed that the mean total score on the PSQ of the non-clinical group was significantly lower than that of the CSA and depression groups and was consistent with the non-clinical mean score of approximately 20 reported by Ryle (2004).

The difference between mean CSA group scores and mean depression group scores was also nearing significance and so an apriori comparison was conducted. A one-tailed, independent samples t-test showed a significant difference ($t(34) = 2.15$, $p<0.05$) with the mean score of the depression group significantly lower than the mean score of the CSA group.

Figure 1 Shows Boxplots of the total PSQ scores.

Figure 1: Boxplot showing total PSQ scores for the three groups



Nevertheless, given that the purpose of employing such questionnaires was to screen for difficulties within the non-clinical group, this was considered to be an interesting finding, and one that might add depth to the analysis, rather than something that might jeopardise the analysis.

3.2.2.2 Beck Depression Inventory Second Edition (BDI-II)

As would be expected given the characteristics of the groups of participants, one way ANOVA indicated there was a significant main effect of group ($F(2,67)=103.56$, $p<.001$) with *post-hoc* Scheffé tests revealing that the mean total score on the BDI-II of the non-clinical group was significantly lower than that of the CSA and depression

groups. Boxplots indicated one outlier score of 14 in the non-clinical comparison group (appendix 7.19), but given that research studies (e.g. Poole *et al.* 2006) advocate a cut-off score of 17 for the BDI-II , this result was retained in the sample.

3.2.2.3 Rosenberg Self Esteem Inventory

One way ANOVA indicated there was a significant main effect of group ($F(2,67) = 82.22$, $p<.001$). *Post-hoc* Scheffé tests revealed that the mean total score on the Rosenberg self esteem inventory of the non-clinical group was significantly higher than that of the CSA and depression groups.

Table 2 shows a summary of the results for the previous two questionnaires over all the groups.

Table 2: Summary of mean scores on BDI-II, and Rosenberg self esteem inventory across the three groups

	CSA Group (n=20) X (SD) Range	Depression Group (n=16) X (SD) Range	Non-clinical Group (n=34) X (SD) Range	Test of difference / association	P
BDI-II	32.80 (10.22) 21-54	29.13 (12.19) 7-49	2.85 (3.30) 0-14	F (2,67) = 103.56	P<0.001
Rosenberg	19.55 (4.20) 13-27	20.94 (5.08) 13-29	33.65 (4.19) 24-40	F (2,67) = 82.22	P<0.001

3.2.2.4 Trauma Symptom Inventory

Of the 10 clinical scales on the TSI, one way ANOVAs and *Post-hoc* Scheffé tests indicated that the non-clinical group, compared to the other two groups, had significantly lower mean scores on the following subscales: anxious arousal ($F(2,67)=65.23$, $p<.001$), depression ($F(2,67)=115.17$, $p<.001$), anger/irritability ($F(2,67)=52.39$, $p<.001$), intrusive experiences ($F(2,67)=53.82$, $p<.001$), defensive avoidance ($F(2,67)=57.13$, $p<.001$), dissociation ($F(2,67)=38.54$, $p<.001$), impaired self reliance $F(2,67)=62.75$, $p<.001$) and tension-reduction behaviour ($F(2,67)=25.11$, $p<.001$).

Sexual concern

One way ANOVA indicated there was a significant main effect of group ($F(2,67)=27.98$, $p<.001$). *Post-hoc* Scheffé tests revealed that the mean sexual concern score for the CSA group was significantly higher than that of the other 2 groups.

Dysfunctional sexual behaviour

One way ANOVA indicated there was a significant main effect of group ($F(2,67)=5.17$, $p<.01$). *Post-hoc* Scheffé tests revealed that the mean dysfunctional sexual behaviour score for the non-clinical group was significantly lower than that of the CSA group.

A summary of the results for all the clinical sub-scales of the TSI is shown in table 3.

Table 3: Mean scores of all sub-categories of the TSI across the three groups

	CSA Group (n=20) X (SD) Range	Depression Group (n=16) X (SD) Range	Non-clinical Group (n=34) X (SD) Range	Test of difference / association	P
Anxious arousal	14.00 (3.91) 6-22	15.81 (5.62) 3-23	4.21 (2.81) 0-12	F (2,67) = 65.23	P<0.001
Depression	18.10 (5.24) 8-24	17.00 (5.37) 0-22	2.94 (2.09) 0-9	F (2,67) = 115.17	P<0.001
Anger/ irritability	17.10 (5.81) 7-27	16.63 (5.94) 4-27	5.26 (3.21) 0-14	F (2,67) = 52.39	P<0.001
Intrusive experiences	14.85 (4.95) 5-24	11.69 (5.67) 1-20	2.85 (3.16) 0-15	F (2,67) = 53.82	P<0.001
Defensive avoidance	16.05 (4.97) 3-23	15.06 (5.12) 5-23	3.35 (4.55) 0-17	F (2,67) = 57.13	P<0.001
Dissociation	14.65 (6.25) 4-26	12.94 (6.10) 2-24	3.82(2.81) 0-12	F (2,67) = 38.54	P<0.001
Sexual concern	11.15 (5.53) 1-24	4.63 (4.84) 0-14	1.79 (3.45) 0-19	F (2,67) = 27.98	P<0.001
Dysfunctional sexual behaviour	3.95 (4.71) 0-19	2.31 (4.03) 0-12	0.76(2.30) 0-13	F (2,67) = 5.17	P<0.01
Impaired self-reliance	14.80 (4.78) 3-24	15.00 (6.14) 0-24	2.97 (3.15) 0-13	F (2,67) = 62.75	P<0.001
Tension-reduction behaviour	7.90 (4.40) 1-17	5.13 (4.33) 0-15	1.26 (1.93) 0-10	F (2,67) = 25.11	P<0.001

The results of all four questionnaires are as desired in order to distinguish between clinical and non-clinical groups.

3.2.3 History of childhood sexual abuse

The characteristics of abuse history were examined for the CSA group. Table 4 shows periods of abuse and number of perpetrators of each period of abuse.

Table 4: Number of discrete periods of abuse and number of perpetrators of each period of abuse

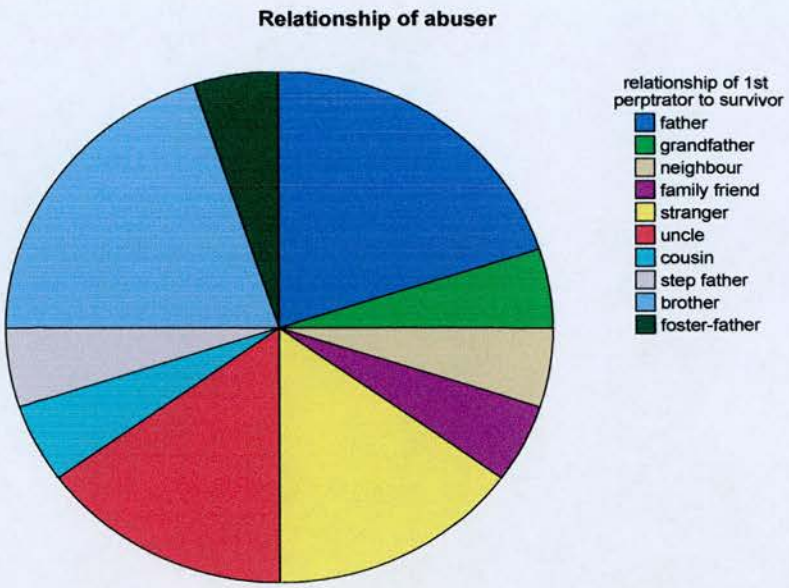
Number of periods of abuse	***Frequency***	***Percentage***	***Number of perpetrators***	***Frequency***	***Percentage***
One period	*15*	*75%*	*One perpetrator*	*13*	*65%*
			Two perpetrators	*1*	*5%*
			Five perpetrators	*1*	*5%*
Two periods	*2*	*10%*	*Two perpetrators*	*2*	*10%*
Three periods	*3*	*15%*	*Three perpetrators*	*3*	*15%*
Total		***100%***	***Total***		***100%***

This shows that while 75% of the CSA group were abused over one discrete period of time, from that 75%, 65% were abused by 1 person, while 10% were abused by more than one person. 10% of participants were abused by two separate people at two different times in their childhood while 15% were abused by three separate people at three different times.

Although 25% of participants had experienced more than one period of abuse, all but 1 participant (95%) had experienced repeated abuse by at least one perpetrator. Participants were also asked whether they had been able to disclose the abuse at the time. 20% (n=4) reported that they had disclosed at the time.Participants were asked to recall what age they were when they were first sexually abused. First instance of abuse ranged from 2-14 years (mean age = 6.30, SD = 3.47).

Figure 2 shows the relationship of first abuser to participant.

Figure 2: Relationship of first abuser to participant



This shows that CSA participants had been abused a range of perpetrators, from very close relatives, including fathers, grandfathers and brothers, to neighbours and strangers.

3.3 Hypothesis Testing

Each hypothesis was tested using inferential statistics. One-way ANOVAs were used to investigate all main hypotheses. Independent samples t-tests were used to investigate a priori and a postiori hypotheses. The results for each hypothesis are reported below.

3.3.1 Hypothesis 1 – Self concept

a. Women who have a history of childhood sexual abuse and women who are depressed will attribute fewer positive and more negative words to themselves relative to a non-clinical sample.

b. The groups will be further differentiated in that women who have a history of childhood sexual abuse will attribute more CSA words to themselves than the other two groups.

This was investigated by examining the positive, negative and CSA words endorsed by the 3 groups when considering general self concept.

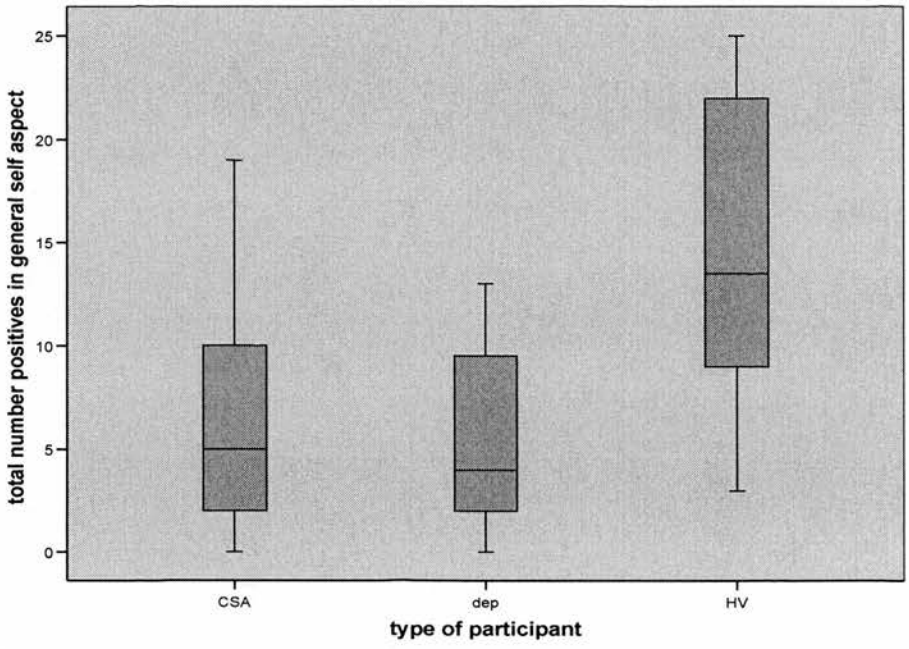
3.3.1.1 Analysis relating to hypothesis 1a. – Use of positive and negative words in describing general self concept .

i) Positive words

A one-way ANOVA indicated there was a significant main effect of group ($F(2,67)=17.42$, $p<.001$). *Post-hoc* Scheffé tests revealed that the non-clinical group used significantly more positive words to describe general self aspect than the CSA and depression groups.

Figure 3 shows a comparison of number of positive words used.

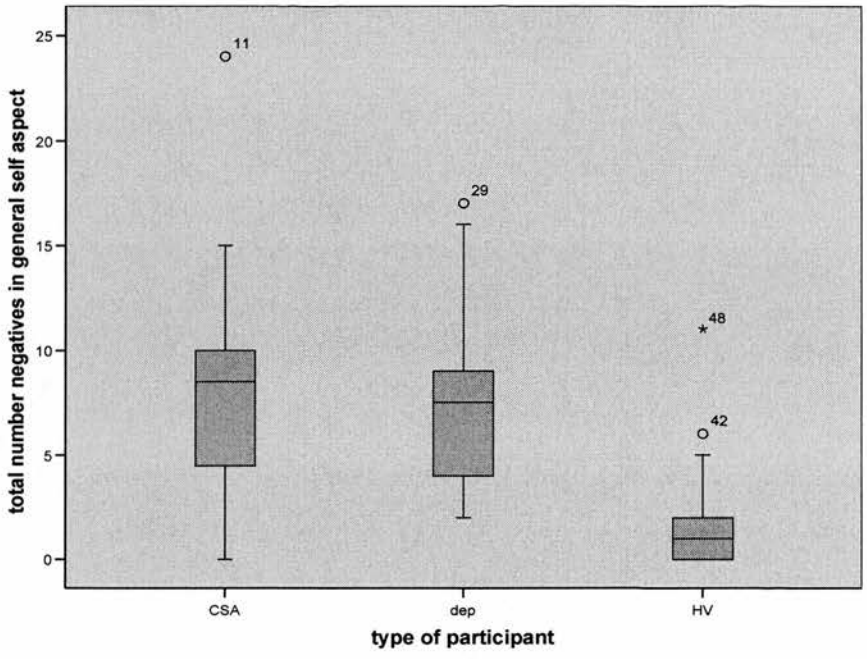
Figure 3: Boxplot showing mean number of positive words (with ranges) used by CSA, depression and non-clinical groups, when describing general self aspect.



ii) Negative words

A one-way ANOVA indicated there was a significant main effect of group ($F(2,67)=23.06$, $p<.001$). *Post-hoc* Scheffé tests revealed that the non-clinical group used significantly fewer negative words to describe general self aspect than the other two groups. Figure 4 shows a comparison of mean number of negative words used.

Figure 4: Boxplot showing total number of negative words (with ranges and outliers) used by CSA, depression and non-clinical groups, when describing general self aspect

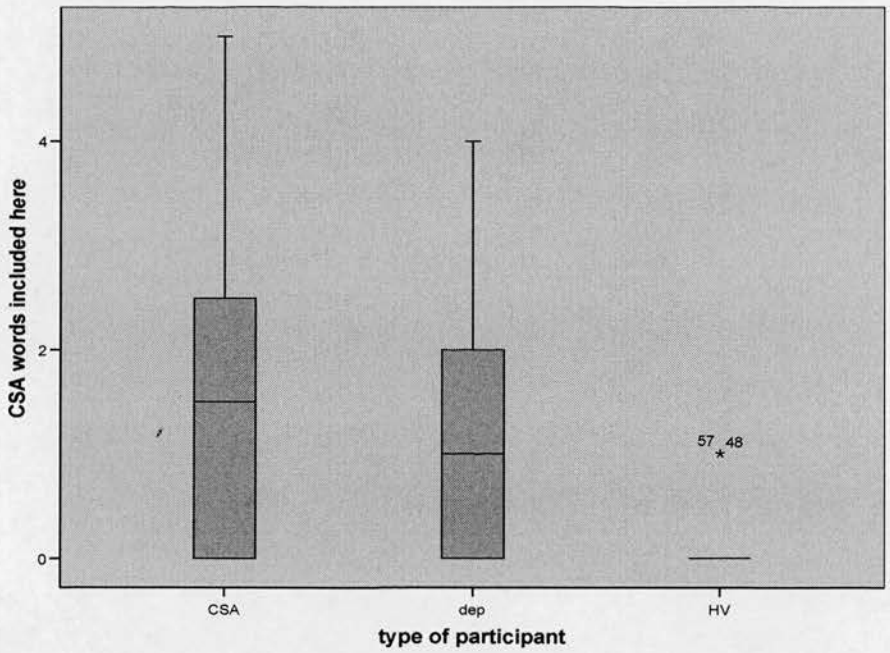


Therefore main hypothesis 1a is supported and the null hypothesis can be rejected.

3.3.1.2 Analysis relating to hypothesis 1b. – Use of CSA words in describing general self concept.

A one-way ANOVA indicated there was a significant main effect of group ($F(2,67)=15.33$, $p<.001$). *Post-hoc* Scheffé tests revealed that the non-clinical group used significantly fewer CSA words when describing general self aspect than the CSA and depression groups. Figure 5 shows a comparison of mean number of CSA words used.

Figure 5: A boxplot showing total number of CSA words (with ranges and outliers) used by CSA, depression and non-clinical groups when describing general self aspect.



Therefore the null hypothesis cannot be rejected. As such, there is partial support for main hypothesis 1.

To investigate these differences more closely, the number of positive, negative and CSA words endorsed by the groups in relation to their specific self aspects were examined.

Firstly, self aspects were investigated according to the order that they were given by the participants. For example, if self aspects mother, daughter and friend were given by one participant and wife, sister and nurse were given by another participant, for each participant the self aspects were assigned labels 1, 2 and 3 sequentially.

Secondly, the most common relationship roles were extracted (for example, 'me as a wife') and compared across groups.

These generated the following subsidiary hypotheses:

Subsidiary hypothesis 1) i.

The CSA and Depression groups will attribute fewer positive words and more negative words to specific self aspects than the non-clinical group.

Subsidiary hypothesis 1) ii.

These negative words will differ between groups in that the CSA group will attribute more CSA words to specific self aspects that the other two groups.

3.3.1.3 Analysis relating to subsidiary hypothesis 1) i. Part I examined by order

Self aspects 1 & 2

i) positive words

One way ANOVAs and *Post-hoc* Scheffé tests indicated that the non-clinical group used significantly more positive words to describe self aspects 1 ($F(2,67)=7.26$, $p<.01$) and 2 ($F(2,67)=6.81$, $p<.01$) than the other two groups.

ii) negative words

One-way ANOVAs and *Post-hoc* Scheffé tests revealed that the non-clinical group used significantly fewer negative words to describe self aspects 1 ($F(2,67)=3.82$, $p<.05$) & 2 ($F(2,67)=3.61$, $p<.05$) than the CSA group.

Table 5 shows the mean number of positives and negatives for self aspects 1 and 2.

Table 5 : Mean number of positive and negative words used in self aspects 1& 2

	CSA Group (n=20) X (SD) Range	Depression Group (n=16) X (SD) Range	Non-clinical Group (n=34) X (SD) Range	Test of difference / association	P
SA1 positives	9.10 (5.52) 1-19	7.56 (6.46) 0-23	13.88 (6.29) 5-25	F (2,67) = 7.26	P<.01
SA 1 negatives	4.60(5.56) 0-18	3.81 (5.15) 0-16	1.65 (1.76) 0-6	F (2,67) = 3.82	P<.05
SA2 positives	7.20 (6.11) 0-24	7.38 (3.93) 3-18	12.82 (7.19) 2-25	F (2,67) = 6.81	P<.01
SA2 negatives	4.75(5.51) 0-17	4.31 (5.19) 0-19	1.79 (2.88) 0-13	F (2,67) = 3.61	P<.05

Self aspect 3

i) positive words

A one-way ANOVA indicated there was a significant main effect of group ($F(2,67)=5.38$, $p<.01$). *Post-hoc* Scheffé tests revealed that the non-clinical group used significantly more positive words to describe self aspect 3 than the depression group.

ii) negative words

A one-way ANOVA indicated there was a significant main effect of group ($F(2,67)=4.27$, $p<.05$). *Post-hoc* Scheffé tests revealed that the non-clinical group used significantly fewer negative words to describe self aspect 3 than the CSA group.

Self aspect 4 & 5

i) positive words

One-way ANOVAs and *Post-hoc* Scheffé tests revealed that the non-clinical group used significantly more positive words to describe self aspects 4 ($F(2,67)=6.29$, $p<.01$) & 5 ($F(2,67)=4.08$, $p<.05$) than the depression group.

ii) negative words

One-way ANOVAs indicated there was no significant difference between groups in the number of negative words used to describe self aspect 4 ($F(2,67)=7.51$, p=NS) or self aspect 5 ($F(2,67)=1.61$, p=NS).

Self aspect 6

One-way ANOVAs indicated there was no significant difference ($F(2,67)=0.87$, p=NS) between groups in the number of positive words used to describe self aspect 6, nor was there a significant difference ($F(2,67)=0.91$, p=NS) between groups in the number of negative words used to describe self aspect 6.

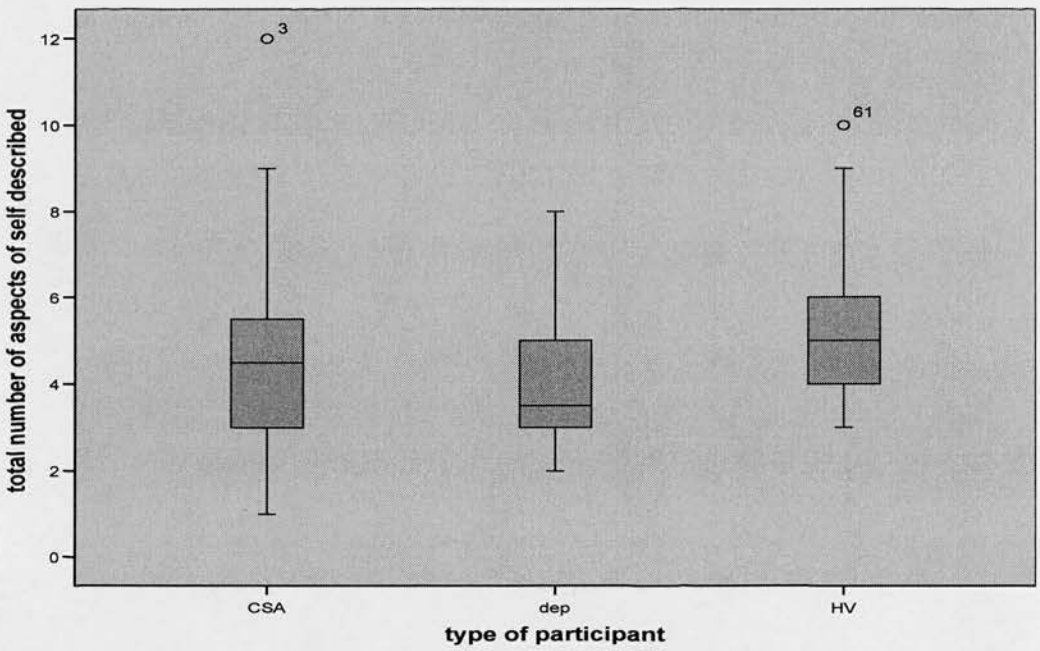
Table 6: Mean number of positive and negative words used in self aspects 3 through to 6.

	CSA Group (n=20) X (SD) Range	Depression Group (n=16) X (SD) Range	Non-clinical Group (n=34) X (SD) Range	Test of difference / association	P
SA3 positives	9.10 (6.46) 0-20	6.75 (6.28) 0-18	12.76 (6.37) (1-24)	F (2,67) = 5.38	P<.01
SA 3 negatives	4.65 (5.64) 0-20	2.44 (3.76) 0-14	1.50 (2.27) 0-9	F (2,67) = 4.26	P<.05
SA4 positives	6.90 (6.43) 0-20	4.06 (6.20) 0-18	10.97 (7.11) 0-25	F (2,67) = 6.29	P<.01
SA4 negatives	2.05 (4.56) 0-20	0.75 (1.34) 0-4	1.47 (3.06) 0-13	F (2,67) = 0.69	P=NS
SA5 positives	5.40 (6.96) 0-18	2.06 (4.45) 0-14	7.82 (7.36) 0-23	F (2,67) = 4.08	P<.05
SA5 negatives	2.30 (3.96) 0-11	1.88 (3.52) 0-12	0.91 (1.49) 0-5	F (2,67) = 1.61	P=NS
SA6 positives	2.70 (5.19) 0-16	0.88 (3.50) 0-14	2.00 (3.70) 0-13	F (2,67) = 0.87	P=NS
SA 6 negatives	0.70 (2.68) 0-12	0.00 (0.00) 0-0	0.97 (2.70) 0-14	F (2,67) = 0.91	P=NS

Although up to 10 self-aspects were discussed by certain individual participants, only data for self concepts 1 to 6 were compared statistically across the 3 groups due to the small number of participants who described 7, 8, 9 & 10 specific self aspects. This is supported by data on the total number of self aspects discussed across the 3 groups. A one-way ANOVA indicated there was no significant difference ($F(2,67)=2.47$, p=NS) between groups in the total number of self aspects described.

Figure 6 shows that the upper quartile for each of the three groups is between 5 and 6 self aspects.

Figure 6: Total number of self aspects described across the three groups



Although there are significant differences between groups in positive and negative words used to describe the initial self concepts discussed, as further self concepts are discussed there are no significant differences. As such, based upon this data from Part I of subsidiary hypothesis 1) i, the null hypothesis cannot be rejected.

3.3.1.4 Analysis relating to subsidiary hypothesis 1 i. Part II (examined by role)

Given that the difference between groups ceased to reach significance when later self aspects were discussed but certain self aspects were commonly mentioned across groups, the data for these common self aspects were extracted and compared across the three groups. The most common self aspects discussed were 'wife' (77% of the whole sample) and 'mother' (86% of the whole sample).

Self aspect: Wife

i) positive words

A one-way ANOVA indicated there was a significant main effect of group ($F(2,56)=10.22$, $p<.001$). *Post-hoc* Scheffé tests revealed that the non-clinical group used significantly more positive words to describe the self aspect 'wife' than the CSA and depression groups.

ii) negative words

A one-way ANOVA indicated there was a significant main effect of group ($F(2,56)=6.90$, $p<.01$). *Post-hoc* Scheffé tests revealed that the non-clinical group used significantly fewer negative words to describe the self aspect 'wife' than the CSA group. However, since the difference between the non-clinical group and the depression group was nearing significance too, an a priori comparison was conducted. A one-tailed independent samples t-test showed a significant difference ($t(12.41) = 1.97$, $p<0.05$) with the non clinical group attributing significantly fewer negative words to the self aspect 'wife' than the CSA group.

Self aspect: Mother

i) positive words

A one-way ANOVA indicated there was a significant main effect of group ($F(2,51)=8.35$, $p<.01$). *Post-hoc* Scheffé tests revealed that the non-clinical group used significantly more positive words to describe the self aspect 'mother' than the depression group.

ii) negative words

A one-way ANOVA indicated there was no significant main effect of group when comparing the number of negative words used to describe the self aspect 'mother'.

In summary, in relation to subsidiary hypothesis 1) i. analysis of data from Part I and Part II do not suggest that the null hypothesis can be rejected.

3.3.1.5 Analysis relating to subsidiary hypothesis 1 ii. Part I (examined by order)

Self aspects 1 to 6

One-way ANOVAs and *Post-hoc* Scheffé tests revealed that the non-clinical group used significantly fewer CSA words when describing self aspect 1 ($F(2,67)=5.79$, $p<.01$), self aspect 2 ($F(2,67)=3.29$, $p<.05$) and self aspect 3 ($F(2,67)=5.96$, $p<.01$) than the CSA group.

There was no significant difference between groups in the number of CSA words used to describe self aspect 4 ($F(2,67)=1.02$, p=NS), self aspect 5 ($F(2,67)=2.09$, p=NS) or self aspect 6 ($F(2,67)=0.51$, p=NS).

Table 7 shows the mean number of CSA words used in self aspects 1-6.

Table 7: Mean number of CSA words used in self aspects 1-6

	CSA Group (n=20) X (SD) Range	Depression Group (n=16) X (SD) Range	Non-clinical Group (n=34) X (SD) Range	Test of difference / association	P
SA1 CSA words	1.00(1.49) 0-5	0.69 (1.01) 0-3	0.12 (.33) 0-1	F (2,67) = 5.79	P<.01
SA2 CSA words	0.60(1.05) 0-3	0.53 (0.83) 0-3	0.12 (.41) 0-2	F (2,67) = 3.29	P<.05
SA3 CSA words	0.50 (0.83) 0-2	0.25 (0.58) 0-2	0.00 (0.00) 0-0	F (2,67) = 5.96	P<.01
SA4 CSA words	0.30(1.13) 0-3	0.00 (0.00) 0-3	0.12 (.33) 0-2	F (2,67) = 1.02	P=NS
SA5 CSA words	0.20 (0.52) 0-2	0.25 (0.78) 0-3	0.00 (.00) 0-0	F (2,67) = 2.09	P=NS
SA6 CSA words	0.15 (0.67) 0-3	0.00 (0.00) 0-0	0.09 (0.38) 0-2	F (2,67) = 0.51	P=NS

3.3.1.6 Analysis relating to subsidiary hypothesis 1 ii. Part II (examined by role)

Self aspect wife:

A one-way ANOVA indicated there was a significant main effect of group ($F(2,56)=4.60$, $p<.05$). *Post-hoc* Scheffé tests revealed that the non-clinical group used significantly fewer CSA words when describing the self aspect 'wife' than the CSA group.

Self aspect mother:

One way ANOVA indicated that there was no significant difference when comparing the number of CSA words used when describing the role of 'mother' ($F(2,51)=3.02$, p =NS). Therefore, in relation to subsidiary hypothesis 1) ii. the null hypothesis cannot be rejected.

3.3.2 Hypothesis 2 – Other women

a. Women who have a history of sexual abuse will attribute more negative words and fewer positive words to other women relative to women who are depressed and a non-clinical sample.

b. These negative words will differ between groups in that the CSA group will attribute more CSA words to other women than the other two groups.

ANOVA, and *post-hoc* Scheffé tests, showed that there was no significant difference between the three groups on the number of other women discussed ($F(2,67) = 7.77$, $p = NS$).

Similarly to the investigation of self aspects, the number of positive, negative and CSA words attributed to each woman was examined, firstly according to the order in which they were discussed and secondly, according to the relationships most commonly discussed, e.g. my mother, my sister.

3.3.2.1 Analysis relating to hypothesis 2a. Part I – Use of positive and negative words in describing other women (examined by order)

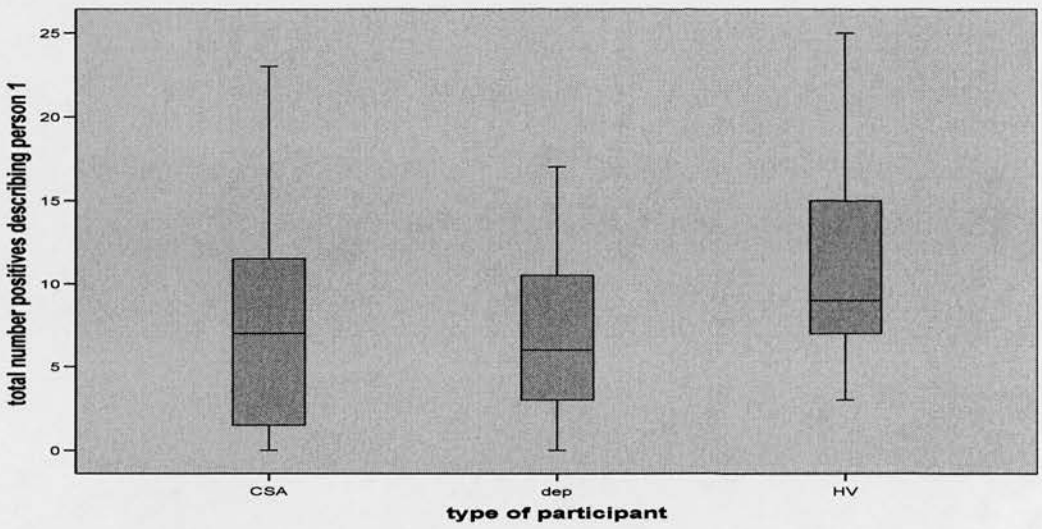
1st women discussed

a. i) positive words

A one-way ANOVA indicated that the difference between groups on the number of positive words attributed to person 1 did not quite reach significance ($F(2,51) = 2.87$, $p = 0.06$). The difference seemed to be accounted for by variance between the non-clinical group and the depression group, therefore an a priori comparison was conducted. A one-tailed independent samples t-test showed a significant difference ($t(48) = -2.40$, $p<0.05$) with the non clinical group attributing significantly more positive words to person 1 than the depression group.

Figure 7 shows the number of positive words attributed to person 1 across the groups.

Figure 7: Number of positive words attributed to person 1 across groups



ii) negative words

ANOVA indicated there was no significant main effect of group when comparing the number of negative words used to describe the first women discussed ($F(2,67) = 1.40$, p = N.S).

Subsequent women discussed

ANOVAs detected no significant difference between groups on the number of positive and negative words attributed to any of the subsequent women discussed (women 2 to 6). As such, based on data from Part I of analysis relating to hypothesis 2a, the null hypothesis cannot be rejected.

3.3.2.2 Analysis relating to hypothesis 2a. Part II – Use of positive and negative words in describing other women (examined by role)

The data for the most common other women discussed: 'mother' (99% of the whole sample), 'friend' (80% of the whole sample) and 'sister' (47% of the whole sample) were extracted and the numbers of positive and negative words were compared between groups.

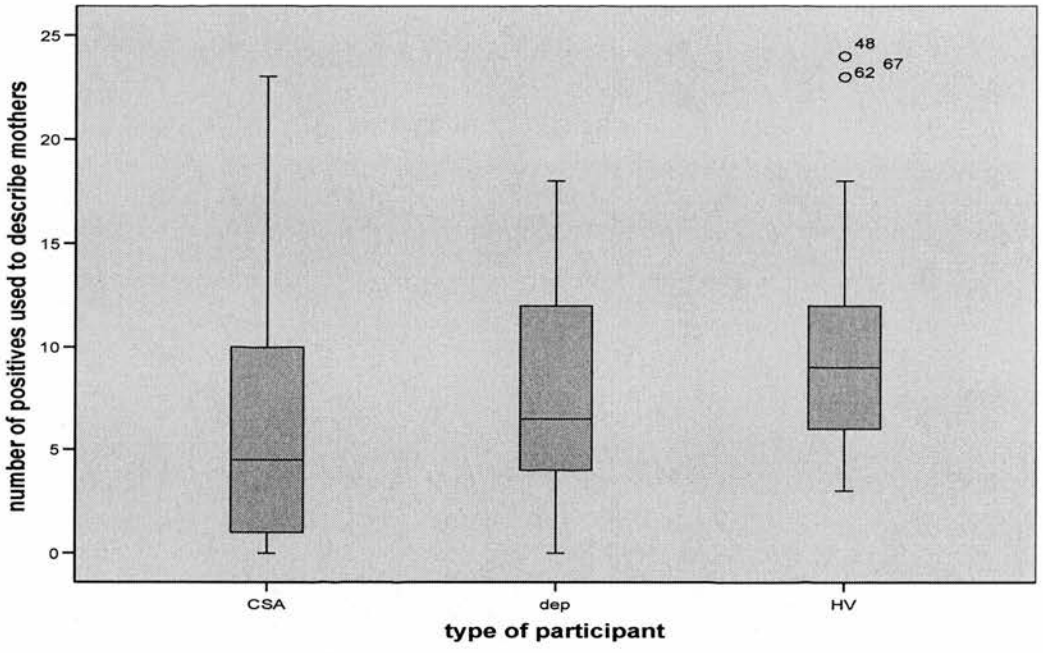
Attributions made about mothers

i) positive words

A one-way ANOVA indicated that the difference between groups did not quite reach significance ($F(2,51) = 2.87$, $p = 0.09$). The difference seemed to be accounted for by variance between the non-clinical group and the CSA group, therefore an a priori comparison was conducted. A one-tailed, independent samples t-test showed a significant difference $t(49) = -2.05$, $p<0.05$ with the non clinical group attributing significantly more positive words to 'mother' than the CSA group.

Figure 8 shows the number of positive words used to describe 'mother', across the three groups.

Figure 8: Number of positive words used to describe mothers over the three groups

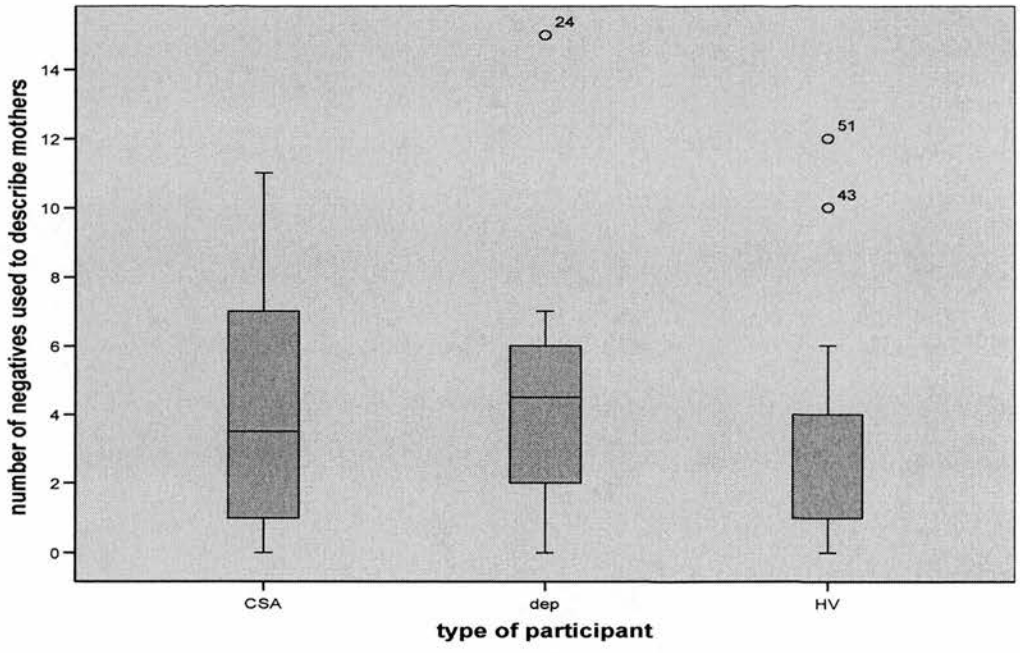


ii) negative words

A one-way ANOVA indicated that the difference between groups did not quite reach significance ($F(2,51) = 2.66$, $p = 0.08$). The difference seemed to be accounted for by variance between the non-clinical group and the depression group, therefore an a priori comparison was conducted. A one-tailed, independent samples t-test showed a significant difference $t(45=2.19$, $p<0.05$ with the non clinical group attributing significantly fewer negative words to 'mother' than the depression group.

Figure 9 shows the number of negative words attributed to mothers, across the three groups.

Figure 9: Number of negative words attributed to mothers across the three groups



Attributions made about friends and sisters

One-way ANOVA detected no significant difference between groups on the number of positive and negative words attributed to 'friend'. Number of positive words ($F(2,67)=0.39$, p=NS); negative words ($F(2,67)=1.67$, p=NS).

One-way ANOVA detected no significant difference between groups on the number of positive or negative words attributed to 'sister'. Number of positive words ($F(2,67) = 0.68$, p=NS), negative words ($F(2,67) = 2.30$, p=NS).

Consequently, data from Part II indicates that hypothesis 2a. is only partially supported.

3.3.2.3 Analysis relating to hypothesis 2b. Part I – Use of CSA words in describing other women (examined by order)

No significant differences were found between groups on the number of CSA words used to describe any of the women when they were compared in sequential order.

Therefore information from Part I of analysis relating to hypothesis 2b. suggests that the null hypothesis cannot be rejected.

3.3.2.4 Analysis relating to hypothesis 2b. Part II – Use of CSA words in describing other women (examined by role)

Mother

A one-way ANOVA indicated there was a significant main effect of group ($F(2,51)=3.79$, $p<.05$). *Post-hoc* Scheffé tests revealed that the non-clinical group used significantly fewer CSA words to describe 'mother' than the CSA group.

Friend

One-way ANOVA indicated no significant difference between groups on the number of CSA words used to describe 'friend' ($F(2,52)=0.93$, p=N.S).

Sister

A significant difference was indicated between the depression and non-clinical groups on number of CSA words, but boxplot indicated that this could be attributed to an outlier in the depression group (appendix 7.21)

Therefore information from Parts I and II of the analysis relating to hypothesis 2b. suggests that the null hypothesis cannot be rejected.

3.3.3 A postiori analysis

Given the above results, and the descriptive statistics of the CSA group, it seemed that there may be a degree of variation between participants in the CSA group, which might be having an impact upon statistical results. Consequently, this group was split according to a) age at which abuse began and b) relationship of perpetrator to the participant, and comparisons drawn between groups on self aspects and attributions about other women.

CSA group split according to age abuse began

Given that the mean age at which abuse began was shown in 3.1.3 to be 6.30 years, age 6 years was taken as the cut-off point between the two groups.

3.3.3.1 A postiori Hypotheses 1 & 2

Women whose abuse began at a younger age will attribute fewer positive words, more negative words and more CSA words to the roles of 'mother' and 'wife' than those whose abuse began when they were older.

A one-tailed independent samples t-test detected no significant difference between the two groups on the number of positive, negative and CSA words attributed to the role of mother. Number of positive words ($t(14)=0.61$, p=NS); negative words ($t(14)=0.19$, p=NS); CSA words ($t(14)= 0.00$, p=NS.

A one-tailed independent samples t-test detected no significant difference between the two groups on the number of positive, negative and CSA words attributed to the role of 'wife'. Number of positive words ($t(16)=0.30$, p=NS); negative words ($t(16)= -1.18$, p=NS); CSA words ($t(7.32)= -1.17$, p=NS.

Therefore the null hypothesis cannot be rejected.

3.3.3.2 A postiori Hypothesis 3

Women whose abuse began at a younger age will attribute fewer positive words and more negative words to mothers than those whose abuse began when they were older.

A one-tailed independent samples t-test showed a significant difference ($t(16)=-2.81$, $p<0.01$) with those who were abused from a younger age attributing significantly fewer positive words to 'mother' than those whose abuse started when they were older.

A one-tailed independent samples t-test showed a significant difference ($t(15.03)=2.51$, $p<0.05$) with those who were abused from a younger age attributing significantly more negative words to mothers than those whose abuse started when they were older.

Therefore a postiori hypothesis 2 is upheld and the null hypothesis can be rejected.

3.3.3.3 A postiori Hypothesis 4

Participants who were abused from a younger age will attribute more CSA words to mothers than those who were older when the abuse began.

A one-tailed independent samples t-test detected no significant difference between groups on the number of CSA words attributed to mothers. ($t(16)= 0.47$, p=NS)

Therefore the null hypothesis cannot be rejected.

The two CSA groups were also split according to the relationship of the perpetrator.

3.3.3.4 A postiori hypothesis 5 and 6

Women whose abusers were close family members will attribute fewer positive words, more negative words and more CSA words to the roles of mother and wife than those whose abuse began when they were older.

No significant differences were found between CSA participants when the group was split according to relationship with the perpetrator: close family member versus not close family member

3.3.3.5 A postiori hypothesis 7 & 8

Women whose abusers were close family members will attribute fewer positive words and more negative words to mothers than those who were abused by someone who was not a close family member.

No significant differences were found between CSA participants when the group was split according to relationship with the perpetrator: close family member versus not close family member.

4. Discussion

This study explored self concept and attributions made about other women by women with a history of CSA, compared to the self concept and attributions made by women with depression and healthy non-clinical volunteers. This was done using a card sort task originally developed by Zajonc (1960) and adapted by Showers (1992). The self concept was examined both in general terms and considering specific aspects of self. Attributions about other women were investigated using participants' self-generated examples of those who currently or previously played a part in their lives.

Interpretation and discussion of the results relating to each of the hypotheses in turn will be followed by consideration of the methodological, clinical and ethical implications of the study, before ending with suggestions for further research.

4.1 Interpretation of the results

4.1.1 Hypothesis 1 - Self concept

There were a number of component parts to the analysis of hypothesis 1. These will be discussed individually.

4.1.1.1 Hypothesis 1a – Use of positive and negative words in describing general self concept.

In comparison with a healthy non-clinical comparison group, women with a history of CSA and women who are depressed endorsed significantly fewer positive

characteristics and significantly more negative characteristics when considering general self concept. This suggests that women with a history of CSA and women with depression have a more negative general self concept than a healthy non-clinical comparison group. Therefore hypothesis 1a is upheld.

4.1.1.2 Hypothesis 1b – Use of CSA words in describing general self concept.

The healthy non-clinical comparison group used significantly fewer CSA words when describing general self aspect compared with the CSA and depression groups. However, there was no significant difference in the number of CSA words selected by the two clinical groups. This suggests that the CSA words were endorsed in a similar way to the negative words, i.e. both clinical groups chose them with a higher frequency, in comparison to the non-clinical group, but compared to each other they did not differ. Therefore, the null hypothesis cannot be rejected.

4.1.1.3 Subsidiary hypothesis 1) i. Part I – Use of positive and negative words in describing specific aspects of self (examined by order).

When self aspects were examined in the order in which they were discussed, the non-clinical group used significantly more positive words and significantly fewer negative words to describe self aspects 1 and 2. This suggests that the CSA and depression groups see themselves more negatively and less positively in these initial self aspects than the non-clinical comparison group. This provides some preliminary support for subsidiary hypothesis 1) i.

However, in relation to self aspect 3, the non-clinical group differed significantly from the depression group in the number of positive words used and differed significantly from the CSA group in the number of negative words used. The significant difference in the number of positive words used was repeated in self aspect 4 and 5, but there was no significant difference in the number of negative words used. Self aspect six showed no significant differences between groups.

Thus it seems that the initial self aspects are perceived more negatively by the CSA and depression groups in comparison to the non-clinical comparison group, but this difference becomes less significant as later self aspects are discussed. Therefore the evidence from Part I is that subsidiary hypothesis 1) i. is only upheld in part.

4.1.1.4 Subsidiary 1) ii. Part I – Use of CSA words in describing specific aspects of self (examined by order).

Comparing the initial self aspects discussed revealed that the non-clinical group used significantly fewer CSA words than the CSA group. However, this difference became less significant as subsequent self aspects were discussed. Thus, it seems that for the initial self aspects discussed, the CSA group are more likely than the other two groups to endorse CSA words. This provides some initial support for subsidiary hypothesis 1) ii.

4.1.1.5 Subsidiary hypothesis 1) i. Part II – Use of positive and negative words in describing specific aspects of self (examined by role).

Comparison of the most commonly discussed relationships with others showed that the non-clinical group used significantly more positive words and significantly fewer negative words to describe the self aspect 'wife' than both the clinical groups.

The non-clinical group used significantly more positive words to describe the self aspect 'mother' than the depression group but there was no significant difference in the number of negative words used to describe the self aspect 'mother'.

Once more, the data gathered for part II suggests that subsidiary hypotheses 1) i. is only upheld in part.

4.1.1.6 Subsidiary hypothesis 1) ii. Part II - Use of CSA words in describing specific aspects of self (examined by role).

In comparison to the CSA group, the non-clinical group used significantly fewer CSA words when describing the self aspect 'wife'. However, there was no significant difference between groups when the numbers of CSA words used to describe the role of 'mother' were compared. This suggests that women with a history of CSA may be more likely than a non-clinical group to attribute CSA words to some self aspects, but the null hypothesis cannot be totally rejected.

Therefore in relation to subsidiary hypothesis 1) ii. the null hypothesis cannot be rejected in its entirety.

4.1.2 Hypothesis 2 - Perceptions of Other Women

Once again, there were a number of component parts to the analysis of hypothesis 2 so each will be discussed separately.

4.1.2.1 Hypothesis 2a. Part I – Use of positive and negative words in describing other women (examined by order).

When the other women discussed were examined in order, the only significant difference was that the non-clinical group attributed significantly more positive characteristics to person 1 than the depression group. No significant difference was found between the number of negative characteristics attributed to person one and no significant differences were found between groups when investigating attributions made about subsequent women. This suggests that the clinical groups are no more likely to attribute negative characteristics and no less likely to attribute positive characteristics to other women than the non-clinical group. The evidence from Part I suggests that the null hypothesis cannot be rejected.

4.1.2.2 Hypothesis 2a. Part II – Use of positive and negative words in describing other women (examined by role).

A priori analysis indicated that the non clinical group attributed significantly more positive characteristics to 'mother' than the CSA group and significantly fewer negative characteristics to 'mother' than the depression group. However, no

significant differences were shown between groups in the number of positive and negative characteristics attributed to 'friend' and 'sister'. This suggests that in comparison to the non-clinical group, the CSA group is less likely to attribute positive characteristics to 'mother' and the depression group is more likely to attribute negative characteristics to 'mother'. However, overall evidence from Parts I and II of hypothesis 2a. suggest that the null hypothesis cannot be rejected.

4.1.2.3 Hypothesis 2b. Part I - Use of CSA words in describing other women (examined by order).

No significant differences were found between groups on the number of CSA words used to describe other women when they were compared in sequential order. This suggests that the CSA group is no more likely to attribute CSA words to other women than the other two groups. Therefore information from Part I of the analysis relating to hypothesis 2b. suggests that the null hypothesis cannot be rejected.

4.1.2.4 Hypothesis 2b. Part II – Use of CSA words in describing other women (examined by role).

In comparison to the CSA group, the non-clinical group used significantly fewer CSA words to describe 'mother'. However, no significant difference was found between groups on the number of CSA words used to describe 'friend' or 'sister'.

Therefore information from Parts I and II of the analysis relating to hypothesis 2b. suggests that the null hypothesis cannot be rejected.

4.1.3 A postiori Hypotheses

A number of a postiori hypotheses were considered; they will be discussed in turn.

4.1.3.1 A postiori hypotheses 1 & 2 – Use of positive, negative and CSA words in describing self as 'wife' or 'mother' (comparing the CSA groups split by age at which abuse began).

No significant differences were found in the words used to describe the roles of 'wife' and 'mother' when the data was split according to the age at which abuse began. This suggests that women who were abused from a younger age do not perceive these roles more negatively than women whose abuse began when they were older. Therefore the null hypotheses cannot be rejected.

4.1.3.2 A postiori hypothesis 3 – Use of positive and negative words in describing 'mother' (comparing the CSA groups split by age at which abuse began).

Women who were abused from a younger age attributed significantly fewer positive words and significantly more negative words to 'mother' than those whose abuse started when they were older. This suggests that women who were abused from a younger age are more likely to perceive their mothers negatively than women who were older when the abuse began. As such a postiori hypothesis 3 was upheld.

4.1.3.3 A postiori hypothesis 4 – Use of CSA words in describing 'mother' (comparing the CSA groups split by age at which abuse began).

No significant difference was found between groups on the number of CSA words attributed to 'mother'. This suggests that women who were abused from a younger age are no more likely to attribute CSA words to their mothers than women whose abuse began when they were older. Therefore the null hypothesis cannot be rejected.

4.1.3.4 A postiori hypotheses 5 & 6 – Use of positive, negative and CSA words in describing self as 'wife' or 'mother' (comparing the CSA groups split by relationship of the perpetrator to the survivor).

There was no significant difference in positive, negative and CSA words used to describe the roles of 'mother' and 'wife' when the CSA group was split according to the relationship of the perpetrator to the survivor. This suggests that those who were abused by a close family member are no less likely to attribute positive words and no more likely to attribute negative words and CSA words to these self aspects than women who were abused by someone who was not a close family member. Therefore the null hypothesis cannot be rejected.

4.1.3.5 A postiori hypotheses 7 & 8 – Use of positive, negative and CSA words in describing 'mother' (comparing the CSA groups split by relationship of the perpetrator to the survivor).

There was no significant difference in positive, negative and CSA words used to describe 'mother' when the CSA group was split according to the relationship of the perpetrator to the survivor. This suggests that those who were abused by a close family member are no less likely to attribute positive words and no more likely to attribute negative words and CSA words to their mother than women who were abused by someone who was not a close family member. Therefore, the null hypothesis cannot be rejected.

4.2 Discussion of the Results

The findings of each of the hypotheses will be discussed with reference to previously published research.

4.2.1 Hypothesis 1 - Self concept

4.2.1.1 Hypothesis 1a. - Use of positive and negative words in describing general self concept.

Hypothesis 1a. stated that women who have a history of CSA and women who are depressed would attribute fewer positive and more negative characteristics to themselves relative to a non-clinical sample. Statistical analysis supported hypothesis 1a suggesting that women with a history of CSA and women with depression have a more negative general self concept than a healthy non-clinical population.

This supports previous research that suggests that women with a history of CSA have self loathing and self blaming beliefs about themselves. It also provides further support for the now well-established view that depression has a negative impact upon one's view of oneself (e.g. Beck, 1967, Jehu, 1988). In addition, this study contributes to the literature by employing a methodology not previously used with a CSA population.

4.2.1.2 Hypothesis 1b. – Use of CSA words in describing general self concept.

Although it was predicted that women who have a history of CSA and women who are depressed would both have a more negative general self-concept than a healthy non-clinical comparison group, it was predicted that these two groups would differ in that women who have a history of CSA would attribute more CSA words to themselves than the other two groups.

Analysis relating to hypothesis 1b. showed that the healthy non-clinical comparison group used significantly fewer CSA words when describing general self concept than the CSA and depression groups. However, there was no significant difference between the number of CSA words endorsed by the CSA group and the number of CSA words endorsed by the depression group. This may be because there is no qualitative difference in the negative self concept held by women with a history of CSA and women with depression.

Alternatively, it may be that the words selected for this study, which were based on clinical judgement and a review of the literature, rather than statistical analysis, were not the most appropriate words for identifying qualitative differences between the groups. Also, given that the card sort test has been used primarily in research into depression, both unipolar and bipolar (Power *et al.*, 2002, Showers 1992, Taylor *et al.*, 2007) it may be that there was an insufficient ratio of words that would be differently endorsed by a CSA population in comparison to a depression population sample.

Certainly, the above finding is in contrast to work of Jehu (1988) who suggested that women who have a history of CSA would attribute more specific self loathing and self-blaming beliefs to themselves than women who are depressed.

However, given Kessler *et al.* 's (1993) research indicating that women are twice as likely to develop depression than men and links between CSA and depression (Andrews & Brown, 1988; Burnam *et al.,* 1988; Holmes & Robins, 1987) it seems possible that some women in this study who were in the depression sample had a history of CSA, but had not disclosed this. Certainly, within the course of the study two participants who were referred as clients with depression, subsequently disclosed a history of abuse to the researcher and so they were included in the CSA sample. It is possible that there were others who did not disclose and this may have had an impact on the self-attributions they made.

4.2.1.3 Subsidiary hypothesis 1) i. - Use of positive and negative words in describing specific aspects of self.

Given that in comparison to a healthy non-clinical comparison group, women with a history of CSA and women who are depressed had a more negative general self concept; it was hypothesised that the CSA and depression groups would also attribute fewer positive characteristics and more negative characteristics to specific self aspects than the non-clinical group.

Statistical analysis relating to hypothesis 1)i. showed that when self aspects were investigated in the order in which they were discussed, the CSA and depression groups perceived themselves more negatively and less positively than the non-clinical comparison group, but that this difference became less significant as further self aspects were discussed.

When the most commonly discussed relationships with others were analysed, this revealed that in respect of the role of 'wife', the non-clinical group used significantly more positive words and significantly fewer negative words than the CSA and depression groups. Similarly, the non-clinical group used significantly more positive words to describe the role of 'mother' than the depression group. However, there was no significant difference between groups when comparing the number of negative words used.

The above perhaps suggests that the self aspects that were most salient to each woman were the ones that were discussed first; this may have an influence on general self concept. Data was gathered as to the importance and perceived positivity and negativity of each self aspect discussed, but due to time constraints this data was not analysed. This may provide useful additional information to supplement these findings.

It is interesting that the depression group used significantly fewer positive words than the non-clinical group to describe the role of 'mother' and yet there were no significant differences in the negative words used to describe this role. It may be that there is a qualitative difference in the general negative view of self held by those in the depression and CSA groups. More specifically, it may be that the CSA group tends to attribute more negative words whilst the depression group attribute fewer positive words. However, this would require further analysis.

Given previous research (Herman, 1992) indicating that women with a history of CSA often experience difficulties in the role of 'mother', and findings within this study that 'mother' was an important role for all three groups, it is perhaps surprising that in comparison to the other two groups, the CSA group did not differ significantly in the number of positive and negative words they attributed to this role. However, this is a hopeful finding in that it provides some evidence that certain self aspects may be protected in comparison to a general negative self concept.

4.2.1.4 Subsidiary hypothesis 1) ii. Use of CSA words in describing specific aspects of self.

Subsidiary hypothesis 1) ii. stated that the CSA group would attribute more CSA words to specific self aspects than the other two groups. Statistical analysis showed that on comparing the initial self aspects discussed, the non-clinical group used significantly fewer CSA words than the CSA group, but there were no significant differences between the non-clinical group and the depression group or between the depression group and the CSA group. However, there did appear to be a trend in the direction of the CSA group. Nonetheless, this difference became less significant as subsequent self aspects were discussed.

When considering 'wife' as one the most common relationships discussed, once more the non-clinical group used significantly fewer CSA words in comparison to the CSA group. There was no significant difference between the non-clinical group and the depression group or between the depression group and the CSA group. However, the number of CSA words endorsed suggested a trend, with the non-clinical group endorsing fewest words and the CSA group endorsing the greatest number. However, the above pattern was not repeated in the case of the role of 'mother'. There was no significant difference between groups when the numbers of CSA words used were compared. Nevertheless, there seemed to be a tendency for the non-clinical group to use fewer CSA words and for any differences to become less significant as more self aspects were discussed. Again, the CSA words did not differentiate between clinical groups.

It might be tentatively suggested that the role of 'wife' is one area where the CSA group experiences particular difficulties. This would be consistent with the finding that the only subscale on the TSI that differentiated the two clinical groups was the sexual concern subscale, although, in addition, there was a trend in this direction on the dysfunctional sexual behaviour subscale with the non-clinical group scoring significantly lower than the CSA group and the depression group scoring between these other two groups. However, further investigation would be required.

4.2.2 Hypothesis 2 – Perceptions of other women

4.2.2.1 Hypothesis 2a - Use of positive and negative words in describing other women.

Given that women who have a history of CSA view themselves negatively, and that difficult relationships with other women have been reported (Herman, 1981), it was hypothesised that women who have a history of CSA would attribute more negative characteristics and fewer positive characteristics to other women relative to women who are depressed and a non-clinical sample.

When the data for other women was examined in the order in which they were discussed, although statistical analysis showed that the non-clinical group attributed significantly more positive characteristics to person one than the depression group, no significant difference was found between the number of negative characteristics attributed to person one and no significant differences were found between groups when investigating attributions made about subsequent women.

When examining the data regarding specific other women discussed, the non-clinical group attributed significantly more positive characteristics to 'mother' than the CSA group and significantly fewer negative characteristics than the depression group. However, no significant differences were shown between groups in the number of positive and negative characteristics attributed to 'friend' and 'sister'. It should be considered at this point that due to time restraints, only data for the first 'sister' and 'friend' were analysed; it was not possible to investigate attributions made to a number of friends. This may have had an impact on outcome.

Since these differences are very subtle, it is difficult to draw any firm conclusions. It is interesting that the only way in which the CSA group differed from the non-clinical group was in the fewer number of positive words attributed to 'mother'. Given that difficult relationships with mothers is the issue most often discussed in other studies when relations with other women are considered, (Peters, 1988; Meiselman, 1978) it is perhaps unsurprising that a survivor may feel that fewer positive traits can be attributed to her mother. However, no significant difference in the number of negative words used by survivors may be an indication of Meiselman's (1978) contention that despite difficult relationships, survivors find it hard to break away from their mothers; they may even find it hard to acknowledge negative feelings.

What is perhaps surprising is the significantly greater use of negative words to describe mothers, employed by the depression group. Again, it is possible that this is due to women who have not disclosed a history of CSA and who are attempting to

come to terms with these experiences by other means. Or it can be suggested that given Peters's (1988) finding that the strongest predictor of long-term psychological difficulties was degree of maternal warmth, it can be argued that this may have implications for experiences of single psychological difficulties, not just the combination that may be found in CSA survivors.

4.2.2.2 Hypothesis 2b - Use of CSA words in describing other women.

On the basis that few significant differences were found between the positive and negative words attributed to other women, it is perhaps unsurprising that no significant differences were found between groups on the number of CSA words used to describe other women when they were compared in sequential order. However, it is interesting to note that once again that the CSA group used significantly fewer CSA words to describe 'mother' than the non-clinical group. Despite this, given that no significant difference was found between groups on the number of CSA words used to describe 'friend' or 'sister', this is an isolated result.

It is of note that although the clinical groups used significantly more CSA words than the non-clinical group when describing themselves, there were few significant differences in the number of CSA words used to describe other women. This suggests that women with depression or history of CSA are more likely to judge themselves (rather than other women) in a negative way, this including the attribution of CSA words.

Alternatively, as suggested in the discussion of hypothesis 1b, it is possible that the words used here were not tapping into self-blaming and self-loathing beliefs and so not differentiating between depression and CSA groups. Furthermore, it must be considered that as the card sort test was designed to investigate self concept; its application to investigating the attributions made about other women may not be appropriate. This will be discussed further in section 4.3.1.5.

4.2.3 A postiori Hypotheses

4.2.3.1 A postiori Hypotheses 1 & 2 – Use of positive, negative and CSA words in describing self as 'wife' or 'mother' (comparing the CSA groups split by age at which abuse began).

Statistical analysis showed no significant differences between the two CSA groups on the number of positive, negative and CSA words attributed to the role of 'mother' or the role of 'wife' when the group was split according to age at which abuse began. This suggests those who were of a younger age when the abuse began are no less likely to attribute positive characteristics and no more likely to attribute negative characteristics or CSA words to these two roles than women who were older when the abuse began.

This is surprising given that previous research has shown that age at which abuse began is an important factor in the long-term consequences of abuse (Beitchman *et al.,* 1992) and that women with a history of CSA often have difficulties in their relationships with partners and children (Kallstrom-Fuqua *et al.* 2004).

4.2.3.2 A postiori hypothesis 3 – Use of positive and negative words in describing 'mother' (comparing the CSA groups split by age at which abuse began).

It was hypothesised that women whose abuse began at a younger age would attribute fewer positive words and more negative words to 'mother' than those whose abuse began when they were older. Statistical analysis showed that women who were abused from a younger age attributed significantly fewer positive words and significantly more negative words to 'mother' than those whose abuse started when they were older. This suggests that women who were abused from a younger age are more likely to perceive their mothers negatively than women who were older when the abuse began.

This is perhaps unsurprising in that women may perceive that their mothers were to blame for not protecting them, given that they were so young (as suggested by Ainscough & Toon, 1998). For survivors who have their own children and are perhaps overprotective due to their fear of abuse occurring again (Herman, 1992) this may make it more difficult for them to understand how a child so young could be allowed to be so vulnerable. Also the beliefs that are formed at such a young age are more difficult to overcome, given the crucial point in brain development (Briere, 2002).

4.2.3.3 A postiori Hypothesis 4 – Use of CSA words in describing 'mother' (comparing the CSA groups split by age at which abuse began).

Statistical analysis showed no significant difference between groups on the number of CSA words attributed to 'mother'. This is perhaps surprising given that women who were abused from a younger age attributed significantly fewer positive words and significantly more negative words to mothers than those whose abuse started when they were older. Again, the prediction that the particular words labelled as CSA words would differentiate the groups was not supported. As discussed in section 4.2.1.2, this might be attributable to the words selected not having been most appropriate or the use of the card sort being inappropriate in examining attributions made about others (see section 4.2.2.2).

4.2.3.4 A postiori hypotheses 5 & 6 – Use of positive, negative and CSA words in describing self as wife or mother (comparing the CSA groups split by relationship of the perpetrator to the survivor).

It was hypothesised that women whose abusers were close family members would attribute fewer positive words, more negative words and more CSA words to the roles of 'mother' and 'wife' than those who were abused by someone who was not a close family member. However, statistical analysis showed no significant difference in the attributions of these two groups.

It is perhaps surprising that there are no significant differences in the way these roles are seen by those who were abused by a close family member and those who were

not, given that the relationship of the perpetrator is considered to be an important factor in dealing with a history of abuse (Browne & Finkelhor 1986). However, it should be noted that in splitting the CSA group data for this analysis, only the first perpetrator was used. Since a number of women had been abused by more than one person this may have impacted upon the results.

4.2.3.5 A postiori hypotheses 7 & 8 – Use of positive, negative and CSA words in describing 'mother' (comparing the CSA groups split by relationship of the perpetrator to the survivor).

Statistical analysis indicated no significant difference between groups in relation to the positive, negative and CSA words attributed to 'mother'. It is perhaps surprising that those who were abused by a close family member are no less likely to attribute positive words and no more likely to attribute negative words and CSA words to 'mother' than women who were abused by someone who was not a close family member, particularly since as discussed in section 4.2.2.2, the non-clinical group used significantly fewer CSA words to describe 'mother' than the CSA group. However, it is worth noting that these a postiori analyses were conducted because the CSA group sometimes showed wide ranging scores, but by splitting the CSA group this resulted in smaller sample numbers. This may account for the lack of a significant result.

4.3 Methodological considerations

Some possible methodological shortcomings of this study will now be considered. However, it is important to point out that to a large extent they reflect difficulties inherent in researching this topic.

4.3.1 Limitations of the Measures

4.3.1.1 Trauma Symptom Inventory

One potential criticism of this scale (Briere, 1995) is its use of internal validity scales, which serve to screen out participants whose responses may be identified as being so extreme or unvaried that their accuracy should be questioned. The guidelines suggest the data from such participants should be excluded. However, it was the researcher's experience that the data of one participant who did score in the above way was accurate and therefore it was included. Perhaps these validity scales should be used to alert one to double-checking the data, rather than automatically excluding it.

Certainly, McDevitt-Murphy *et al.* (2005) note that while good convergent validity was indicated between the majority of the TSI scales and other self-report measures of PTSD, (between r =.28 and r =.73) this was not the case for the inconsistent response scale. The authors also note that given that it is a self-report measure, it could not be considered appropriate to employ the TSI as a diagnostic tool for PTSD.

4.3.1.2 Rosenberg self esteem inventory

It should be noted that some studies (e.g. Shahani, *et al.,* 1990) have indicated the presence of two factors within the Rosenberg self esteem inventory, (Rosenberg, 1989) whilst others (including Rosenberg) have only identified one. However, many studies support its validity and reliability as a measure of self esteem and there was nothing in this study to suggest that it did not appropriately distinguish between groups.

4.3.1.3 Personality Structure Questionnaire

While Pollock *et al.* (2001) showed good test-retest, convergent and discriminant reliability of this measure, (reliability of $\alpha = .77$ in a clinical sample of psychotherapy patients, $\alpha = 0.87$ in a BPD sample, test-retest reliability, $r = .75$) it is a relatively new tool and as yet its use has not been reported in the literature. However, in this study, apart from the sexual concern subscale of the TSI, this was the only measure to distinguish between the two clinical groups.

4.3.1.4 Beck Depression Inventory (BDI-II)

Although the scale has been validated with a number of clinical populations, (adult psychiatric outpatients and inpatients, substance abusers and patients with chronic pain (Ball & Steer, 2003; Cole *et al.*, 2003; Buckley *et al.,* 2001, Poole *et al.*, 2006, respectively) some interesting criticisms were made about the BDI-II by a number of participants in the non-clinical group. For example, it was noted that the question about sadness did not have an intermediate option between 'I do not feel sad' and 'I feel sad much of the time'. Another participant, whose score was at the high end of the normal range, questioned the lack of an option about having an increased sex

drive, her comment appearing to relate to her disappointment with her life. Arguably, however, her relatively high score indicates that the BDI-II was identifying her degree of unhappiness. Further, more importantly, the measure was fit for purpose in that it did distinguished level of depressed mood between groups.

4.3.1.5 Self-concept card sort test

As discussed in section 1.8, the card sort test was chosen over the repertory grid technique because, like the repertory grid, it has been used to assess how individuals perceive aspects of themselves, but without the potentially constraining aspect of bipolar constructs. Given the third hypothesised way in which survivors may perceive other women, i.e. that they may perceive them in a polarised fashion, it was considered important to avoid using a method that might encourage participants to attribute only positive or only negative adjectives, so that at a later date this data could be used to investigate the third hypothesis without the concern that the method of investigation was somehow biased towards supporting the hypothesis.

However, as mentioned previously, the card sort test was designed to measure self concept and may not be appropriate for use in investigating attributions made about others. In addition, given that it was developed with a depressed population in mind (Showers, 1992, Taylor *et al.*, 2007) there may have been a bias towards depression trait adjectives, which skewed results.

4.3.2 Limitations of the Sample

Women who were recruited for the clinical groups were at various stages in therapy. Some had only recently been assessed for individual treatment, others had been attending for individual therapy for varying lengths of time and still others were attending or had recently attended group therapy. Consequently, they may have already worked on changing elements of self concept and may have considered factors that contribute to relationship difficulties within therapeutic sessions and this may have had an impact upon results. Certainly, in their study of gender role perceptions of women in abusive relationships, Ellington and Marshall (1997) excluded women who had recent or extensive experience of therapy or those whom they thought had been influenced by therapy, to ensure that the attributions they made were their own. Ideally, participants would have been limited to those about to embark on therapy and with no previous experience of therapy. However, time constraints did not allow this.

Also, given that the researcher did not recruit participants and she was not familiar with the history of each individual, there is the potential that members of the depression group may have had a history of CSA, without the researcher being aware of it, despite all possible precautions being taken against this. For example, an information sheet was provided for clinicians (appendix 7.8) outlining the design and methodology of the study, and repeated clarification was provided about recruitment criteria at research and psychology department meetings.

Similarly, as Beitchman *et al.* (1992) comment that non-clinical samples do not represent randomised controls and they are often biased in some way, it is possible that given the nature of the study, some of the women in the non-clinical group may have had experience of CSA or depression, although it might be argued that the results of the BDI-II and TSI questionnaires provide some reassurance that the samples were differentiated.

4.3.3 Time Constraints

Had time allowed, a number of further analyses would have been conducted. As noted in section 4.2.1.2, there were concerns regarding the CSA words used. Aware of this, for each self aspect and other women discussed, the researcher asked participants if there were any additional words they would like to include. These were not used in the analysis but it was hoped that they might be studied if time allowed. Unfortunately it did not.

Data were gathered from participants regarding ratings of importance and positivity and negativity of individual self aspects and perceptions of other women. It was the researcher's intention to analyse these data and this may have provided additional information with regard to the salience of some of the self aspects and other women discussed.

Many participants discussed a variety of other women with whom they have had some sort of relationship with, a number of whom could be classified in the same category e.g. 'sister' and 'friend'. As noted in section 4.2.2.1, a postiori analyses

only examined the first women in such categories, which may have had an impact on the results obtained.

The inclusion of the PSQ within this study was to allow the investigation of whether the attributions made by different samples of women, rather than simply being either more or less negative, were actually polarized. More specifically, the researcher questioned whether, if an individual has a less integrated sense of themselves (according to the CAT Multiple Self States Model, what would be known as a borderline personality structure) they would have a more polarized view of aspects of themselves and other women. Further, if the CSA group had a less integrated sense of themselves, (as measured by the PSQ) then it was expected that they would have a more polarized view, i.e. seeing aspects of themselves or other women in either very positive and very negative (but rarely balanced) terms. What is interesting is that the PSQ showed a significant difference between the scores of the CSA and depression groups as well as the non-clinical groups. The mean for the clinical group being just below the normal mean score (20), the mean for the depression group being slightly below the suggested cut off score (28), for borderline personality and the mean score for the CSA group being above this and slightly above the mean score (30) for borderline personality patients, (the above means reported by Pollock *et al.*, 2001). This may suggest that the PSQ might be a useful screening tool, especially given the short time it takes to complete.

4.3.4 Design Limitations

Some individuals commented that with particular words they found it difficult to remember that they were being asked about their perception of other women rather than another woman's perception of herself. Therefore, potentially participants chose characteristics that they believed another woman would attribute to herself rather than a characteristic they saw in her.

Also, the level of reading difficulty of the words used was not assessed. This may have been important in that although participants rarely asked what a word meant, they may have been unsure as to the pronunciation or meaning of some words and subsequently did not choose those words. Perhaps this could have been done using the Flesch formula (Flesch, 1948). Similarly, care was chosen not to include words that may have been ambiguous (i.e. could be interpreted positively or negatively) for example 'sexy' but other words may have been interpreted this way. Ideally, a pilot study could have been conducted to confirm that words were either seen as positive or negative, and not ambiguous.

Potentially, a limitation of this study is the particular words that were chosen as CSA words. It may be that these words were not the most striking or pertinent words that could have been selected, thus making them less powerful in the study. Similarly, it is possible that few differences have been found between the CSA and the depression groups because there were more words from the depression literature (given that that

was the area of Showers (1992) research). Perhaps more words from the CSA literature should have been included to provide more of a balance.

The words chosen were from a review of the literature, discussions with other clinicians and the researcher's own clinical experience. However, literature on the topic of perceptions of other women held by those who have a history of CSA is sparse. It was difficult to identify words that women might use to describe themselves and other women. For example, words that women with a history of CSA might use to describe themselves are 'dirty', 'contaminated'. However, it seemed unlikely that they would use these to describe other women. Thus, perhaps it was unrealistic to try and identify a common set of words that would differentiate the attributions made by CSA women, both of themselves and other women. Perhaps, had time allowed, one could do a factor-analysis of the words selected, from the total selection of words, to see if there was any pattern in the words chosen by the different groups, both in describing different aspects of themselves and other women.

Furthermore, the supplementary CSA words added to the word sort task had to be limited in number, and a balance of positive and negative words needed to be included. For example, a negative CSA word was 'shameful' whilst a positive one was 'trustworthy'. Again, if time had allowed, it might have been useful to investigate differences in the selection of positive versus negative CSA words.

4.4 Clinical and Ethical implications

Treatment for women with a history of CSA often involves individual and or group work, which by its nature requires involvement and interactions, primarily with other women. It was argued that assumptions are made that survivors are more comfortable with other women, but since previous research (Herman, 1981; Kallstrom-Fuqua *et al.*, 2004) had indicated that this might not be the case, problematic group/interpersonal dynamics might result.

Given the support found for hypothesis 1a (that survivors have a general negative self concept) but the lack of corresponding support for hypothesis 2 (that survivors will also have a negative opinion of other women) it can be suggested that these results could have implications for therapy. An example of a potentially unhelpful aspect (unless identified and addressed) would be if a survivor compared herself negatively to the therapist or other group members (if in group therapy). This could reinforce a sense of inferiority and being not good enough and in a group situation lead to behaviour such as individuals withdrawing or not participating fully. However, by being aware of the likelihood that an individual may perceive herself, but not other women negatively, a therapist (whether individual or group) may use therapy to actively increase awareness of this and address this issue. For example, group therapy may offer the possibility of a woman becoming aware of the universality of her experiences and difficulties (Chard, 2005) and so recognise herself as not being 'different' or unique. Hopefully this would therefore reduce her perception of herself as being inferior (as Herman, 1992 reports, feeling different is a particular issue for survivors).

Another particularly interesting implication from this study is that given that there were few results that showed significant differences between the clinical groups, it can be suggested that these issues should also be kept in mind when treating women who are depressed. In clinical practice it may be assumed that women with a history of CSA will have more severe and complex difficulties than women who are depressed. However, the lack of difference in the nature of the words chosen may indicate that the groups were not particularly different, and scores on the BDI-II and TSI support this. Furthermore, although the mean scores of two clinical groups on the PSQ and the sexual concern subscale of the TSI were significantly different, which perhaps suggests some subtle differences, there is also the possibility that the CSA group and depression groups were not 'pure' in that a history of CSA may have been present in both samples. Certainly more investigation is required.

A further consideration from these results is that perhaps rather than treating individuals according to which category they can be assigned to, (in this case depression and those with a history of CSA) it may be more relevant to investigate factors such as, what the CAT Multiple Self States Model describes as level of personality integration (Ryle, 1997).

Given the negative cognitive triad (Beck, 1967), it could have been argued that rather than women with a history of CSA having a more negative view of other women, that both the depressed women and women with a history of CSA are as likely to have a negative view of other women. However, the data did not support this argument.

The researcher was conscious that for some participants more time was required for them to complete the research tasks, and that in some cases they were invited back for a second research session. It could be argued that, given participants were told in the information sheet that they would only be required to attend for a single session lasting approximately 1 hour, this would be considered unethical. However, on the other hand, in general, extra time was provided to allow participants to ask questions or make comments that they felt were important and not to feel constrained or hurried. To have prevented this, it could be argued, would be unethical.

4.5 Future research

4.5.1 Analysis of existing data

4.5.1.1 Personality Structure Questionnaire (PSQ)

To investigate the possibility that women with a history of CSA will have a less integrated sense of self and that this in turn will be associated with them having a more polarized view of aspects of themselves and other women, one could take the following steps. Divide the whole sample according to whether they had a clinically significant score on the PSQ and then compare these two groups to see if there was evidence of a difference in polarity in the attributions made. It would be expected that those who scored highly on the PSQ would make more polarized attributions regarding themselves and others. If supported, one could then look for evidence of differences between clinical and non-clinical groups.

4.5.1.2 Differences in words selected between groups and across different conditions.

It would be useful to do further data analysis on the self-generated words from each of the participants, as this may identify different words that different groups found relevant. In addition, it could be worthwhile carrying out an analysis between groups to see if there was a difference in the words that they selected to describe themselves and others. Moreover, as mentioned in section 4.3.3, it may prove enlightening to also consider the ratings of importance and perceived positivity and negativity of the self aspects and other women discussed.

4.5.1.3 Self-complexity

It might have been interesting to investigate self-complexity by examining how often the same words were used across different self aspects, given that other studies have shown that the content of self aspects may be just as important as the organisation of self aspects (Taylor *et al.*, 2007).

4.5.2 Analysis beyond the current data set

4.5.2.1 General concept of other women

It could be useful to investigate general concept of other women in future research studies to allow comparisons to be made between how women perceive themselves in general and how they perceived other women in general.

4.5.2.2 Investigation of factors relating to abuse

A postiori comparison involved investigation of the impact of factors relating to sexual abuse. While some significant differences were found, one might have expected more significant results based on previous research (Beitchman *et al.* 1992; Browne & Finkelhor 1986; Kallstrom-Fuqua *et al.,* 2004). As noted in section 4.2.3.5, a limitation was the small sample numbers. It could therefore be useful to investigate, using a larger sample size, differences between groups, differentiated according to abuse-related criteria. These criteria could include not only those investigated in this study (i.e. age and relationship with perpetrator) but also criteria not investigated here, such as duration of abuse, which researchers have shown to be significant (Beitchman *et al.*, 1991)

4.5.2.3 Non-clinical sample

This population of CSA survivors was drawn from the group attending mental health services. We know that many women who have a history of CSA do not present to mental health services, and indeed that many do not report difficulties (Baker & Duncan, 1985) so it would be informative to investigate beliefs about other women in a community sample.

5. Conclusion

This study supported the hypothesis that the CSA group and the depression group would perceive themselves more negatively than the non-clinical group. However, the predicted qualitative differences between the two groups, regarding their negative perceptions of themselves was not found.

Subsidiary hypotheses, which looked at specific self aspects of self according to the order in which the aspect was selected and the nature of that aspect, produced varied results, but in general, appeared to support the above findings.

The study did not support the prediction that women with a history of CSA would have a more negative view of other women, relative to a depressed group and a non-clinical group. Indeed, there was no clear-cut evidence of differences between the groups.

Nevertheless, there are some interesting results that may be worthy of further investigation, but at this stage have to be treated with caution.

A postiori analyses did show a significant difference in the attributions made about mothers when comparisons were drawn between women whose abuse began when they were very young, as opposed to those who were older, but otherwise, did not produce significant results.

Whilst, as indicated, this study has limitations, the author considers that its achievements or contributions include, firstly, exploring the use of a card sorting test with a clinical population (women with a history of CSA) with which it has not previously been used and to investigate concepts it has not previously been used to investigate; secondly, it would appear to have provided data supporting the use and validity of the PSQ in distinguishing clinical populations; thirdly, it has made suggestions regarding future research which may further inform our understanding of an area of research, which, to date does not appear to have been the subject of much attention.

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7 Appendices

7.1 Appendix: Ethical Approval Letter

Lothian Local Research Ethics Committee 04

Telephone: 0131 536 9022
Facsimile: 0131 536 9346

17 November 2006

Ms Susan J. McAlpine
Trainee Clinical Psychologist
NHS Lothian/University of Edinburgh
St Johns Hospital
Livingston
West Lothian
EH54 6PP

Dear Ms McAlpine

Full title of study:	**The perceptions that women who have a history of childhood sexual abuse have about themselves and other women.**
REC reference number:	**06/S1104/45**

Thank you for your letter of 02 November 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered by the chair and vice chair on 16 November 2006.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.
Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application		03 October 2006
Investigator CV	academic supervisor Power	
Investigator CV		27 September 2006
Protocol		17 July 2006
Covering Letter		02 October 2006
Letter from Sponsor		20 October 2006
Questionnaire		
Advertisement	HV 1	27 September 2006
Advertisement	HV v2	02 November 2006
Letter of invitation to participant	HV v2 Covering letter for participants	02 November 2006
GP/Consultant Information Sheets	2	02 November 2006
Participant Information Sheet	Patient DEP v 2	02 November 2006
Participant Information Sheet	Patient CSA v2	02 November 2006
Participant Information Sheet	HV v 2	02 November 2006
Participant Consent Form	Paricipant DEP v2	02 November 2006
Participant Consent Form	HV v2	02 November 2006
Participant Consent Form: Reminder letter for participants	CSA v2	02 November 2006
Participant Consent Form	Participant CSA v 2	02 November 2006
Response to Request for Further Information		02 November 2006
In Case of Distress contact details	1	02 November 2006
Reminder letter for participants	DEP v2	02 November 2006
Covering letter for patients	CSA v2	02 November 2006
Covering letter for patients	DEP v2	02 November

		2006
Reminder letter for participants	HV v2	02 November 2006
Response to points 1,7,9		
Covering Letter for Participants	HV 1	27 September 2006
Insurance Details		28 July 2006

Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/S1104/45	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Chair

Email: joyce.clearie@lhb.scot.nhs.uk

Copy to: The University of Edinburgh
Department of Clinical and Health Psychology,
School of Health in Social Science, University of Edinburgh
Medical School, Teviot Place
[R&D Department for NHS care organisation at lead site]

7.2 Appendix: Participant invitation letter

7.2.1 CSA group

REC Ref: 06/S1104/45

Covering letter for patients

CSA version 2 02.11.06

Psychology Department
Tel: 01506 523615

Date:

Dear Ms _____

Thank you for agreeing to take a few minutes to read this letter. It gives some information about research that we are conducting in collaboration with the University for Edinburgh.

You have recently attended St Johns Hospital or your local Health Centre for a Clinical Psychology outpatient appointment. Together, you and your therapist have agreed that currently, you seem to be experiencing problems that relate to a history of childhood sexual abuse. The research that we are involved in looks at the ways that women who have experience of childhood sexual abuse think about themselves and other women. In the future this might help us to plan treatment to take account of such information.

I enclose a few pages that explain the study in further detail.

We would be very appreciative of your time and help in this matter if you felt able to participate in this research.

Please do not hesitate to contact either of us on the above telephone number if you have any questions about the study or if you would like some more information.

Yours sincerely

Susan McAlpine
Trainee Clinical Psychologist

Allison Shanks
Clinical Psychologist

7.2 Appendix: Participant invitation letter

7.2.2 Depression group

REC Ref: 06/S1104/45

Covering letter for patients

DEP version2 02.11.06

Psychology Department
Tel: 01506 523615

Date:

Dear Ms _____

Thank you for agreeing to take a few minutes to read this letter. It gives some information about research that we are conducting in collaboration with the University for Edinburgh.

You have recently attended St Johns Hospital or your local Health Centre for a Clinical Psychology outpatient appointment. Together, you and your therapist have agreed that currently, you seem to be experiencing problems with depressed mood. The research that we are involved in looks at the ways that women think about themselves and other women. In the future this might help us to plan treatment to take account of such information.

I enclose a few pages that explain the study in further detail.

We would be very appreciative of your time and help in this matter if you felt able to participate in this research.

Please do not hesitate to contact either of us on the above telephone number if you have any questions about the study or if you would like some more information.

Yours sincerely

Susan McAlpine
Trainee Clinical Psychologist

Allison Shanks
Clinical Psychologist

7.2 Appendix: Participant invitation letter

7.2.3 Healthy non-clinical comparison group

REC Ref: 06/S1104/45

Covering letter for participants HV version2 02.11.06

Psychology Department
Tel: 01506 523615

Date:

Dear

Thank you for agreeing to take a few minutes to read this letter. It gives some information about research that we are conducting in collaboration with the University for Edinburgh.

You have recently responded to an advert for healthy volunteers to participate in our study. The research that we are involved in looks at the ways that women think about themselves and other women. In the future this might help us to plan treatment to take account of such information.

I enclose a few pages that explain the study in further detail.

We would be very appreciative of your time and help in this matter if you felt able to participate in this research.

Please do not hesitate to contact either of us on the above telephone number if you have any questions about the study or if you would like some more information.

Yours sincerely

Susan McAlpine
Trainee Clinical Psychologist

Allison Shanks
Clinical Psychologist

7.3 Appendix: Reminder letter

7.3.1 CSA group

REC Ref: 06/S1104/45

Reminder letter for participants

CSA version 2 02.11.06

Psychology Department
Tel: 01506 523615

Date:

Dear Ms _____

When you attended for a Psychology outpatient appointment recently, you were given some information about research that we are conducting in collaboration with the University for Edinburgh.

We just wanted to remind you that you are invited to participate in this research if you were interested.

The research that we are involved in looks at the ways that women think about themselves and other women. In the future this might help us to plan treatment to take account of such information.

We would be very appreciative of your time and help in this matter if you felt able to participate in this research.

If you would like to participate, if you have any questions about the study or if you would just like some more information, please do not hesitate to contact either of us on the above telephone number.

Yours sincerely

Susan McAlpine
Trainee Clinical Psychologist

Allison Shanks
Clinical Psychologist

7.3 Appendix: Reminder letter

7.3.2 Depression group

REC Ref: 06/S1104/45

Reminder letter for participants DEP version 2 02.11.06

Psychology Department
Tel: 01506 523615

Date:

Dear Ms _____

When you attended for a Psychology outpatient appointment recently, you were given some information about research that we are conducting in collaboration with the University for Edinburgh.

We just wanted to remind you that you are invited to participate in this research if you were interested.

The research that we are involved in looks at the ways that women think about themselves and other women. In the future this might help us to plan treatment to take account of such information.

We would be very appreciative of your time and help in this matter if you felt able to participate in this research.

If you would like to participate, if you have any questions about the study or if you would just like some more information, please do not hesitate to contact either of us on the above telephone number.

Yours sincerely

Susan McAlpine
Trainee Clinical Psychologist

Allison Shanks
Clinical Psychologist

7.3 Appendix: Reminder letter

7.3.3 Healthy non-clinical comparison group

REC Ref: 06/S1104/45

Reminder letter for participants HV version 2 02.11.06

Psychology Department
Tel: 01506 523615

Date:

Dear Ms _____

You recently requested some information about research that we are conducting in collaboration with the University for Edinburgh.

We just wanted to remind you that you are invited to participate in this research if you were interested.

The research that we are involved in looks at the ways that women think about themselves and other women. In the future this might help us to plan treatment to take account of such information.

We would be very appreciative of your time and help in this matter if you felt able to participate in this research.

Please do not hesitate to contact either of us on the above telephone number if you have any questions about the study or if you would like some more information.

Yours sincerely

Susan McAlpine
Trainee Clinical Psychologist

Allison Shanks
Clinical Psychologist

7.4 Appendix: Advert

7.4.1 Poster

The Psychology Department in St Johns Hospital is conducting some research into the ways that women think about themselves and other women. As we are looking for some healthy volunteers, we would be grateful if any female staff members who would be willing to take part in such a study were able to spare us 1 hour of their time. It would not be advisable to volunteer if you have experienced any traumatic life events.

For initial inquiries please contact Susan McAlpine, Trainee Clinical Psychologist by emailing susan.mcalpine@wlt.scot.nhs.uk or phoning 01506 523615 - at which point further information will be provided.

7.4 Appendix: Advert

7.4.2 Email

REC Ref: 06/S1104/45 HV version 1 27.09.06

Invitation to participate (email)

The Psychology Department in St Johns Hospital is conducting some research into the ways that women think about themselves and other women. As we are looking for some healthy volunteers, we would be grateful if any female staff members who would be willing to take part in such a study were able to spare us 1 hour of their time. It would not be advisable to volunteer if you have experienced any traumatic life events.

For initial inquiries please contact Susan McAlpine, Trainee Clinical Psychologist by emailing susan.mcalpine@wlt.scot.nhs.uk - at which point further information will be provided.

7.5 Appendix: Information Sheet

7.5.1 CSA group

LREC Ref: 06/S1104/45 CSA Version 2 02.11.06

Psychology Department
01506 523615

Patient information sheet

Study Title
The ways that women think about themselves and other women.

Invitation
You are being invited to take part in a research study. Before you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
Studies have shown that some women who have a history of childhood sexual abuse can have negative views of themselves and others. This may lead to problems in everyday social relationships. The study aims to investigate this area further and develop the existing findings. The study will run from autumn 2006 until summer 2007.

Why have I been chosen?
This study is only being carried out in St Johns Hospital and your Psychologist or BSA Group Leader has identified you as a potential participant.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form. If you decide to take part you are free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?
You will be invited to come along to a single session where you will be asked a few brief questions about your history and current situation and to complete a number of questionnaires. You will also be asked to complete an exercise where you are required to choose from a set of cards that have different descriptive words on them

(for example 'happy' and 'sad') according to how much you feel they apply to you and to other people you know.

The session will take place in the Psychology Department at St Johns Hospital and should take no longer than 1 hour.

Expenses and payments

If you are normally entitled to reimbursement of travel expenses for visits to the hospital, you will also be entitled to these expenses for this one-off appointment.

What do I do once I've made my decision?

If you are willing to take part, please contact me on the number overleaf or complete the tear-off slip below and return it to me in the envelope provided. If I have not heard from you within 7 days you will be sent a short reminder letter just in case you have mislaid the information.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name removed so that you cannot be recognised from it. Your GP and your Psychologist or BSA Group Leader will be contacted and told that you will be taking part in the study. However, details of the outcome of the session will be kept confidential unless at any point during the study we are concerned for your well-being or the well-being of someone else.

What will happen to the results of the research study?

The results of the study will be reported in the lead researcher's doctoral thesis. The thesis is being written as part of training to become a Clinical Psychologist. Once it is completed a copy will be available from the University of Edinburgh Library. People who take part in the study will not be identified in the thesis.

Who has reviewed the study?

The study has been reviewed and approved by the Lothian Research Ethics Committee.

Contact for further information

If you have any questions, or if you would like further information, please feel free to get in touch with me using the contact details on the letterhead.

Many thanks once again for taking the time to read this information sheet.

Susan McAlpine
Trainee Clinical Psychologist
Lead Researcher

✂----------

LREC Ref: 06/S1104/45 CSA Version 2 02.11.06

I wish to take part in the research study 'The ways that women think about other women'.

Name:

Telephone number:

7.5 Appendix: Information sheet

7.5.2 Depression group

LREC Ref: 06/S1104/45

DEP Version 2 02.11.06

Psychology Department
01506 523615

Patient information sheet

Study Title
The ways that women think about themselves and other women.

Invitation
You are being invited to take part in a research study. Before you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
Studies have shown that some women who are depressed can have negative views of themselves and others. Other studies have shown that women who have a history of childhood sexual abuse can have negative views of themselves and others. Women who have a history of childhood sexual abuse may also be depressed. For women who are depressed and women with a history of childhood sexual abuse these negative views of themselves and others may lead to problems in everyday social relationships. The study aims to investigate further the nature, similarities and differences of the negative views held. The study will run from autumn 2006 until summer 2007.

Why have I been chosen?
This study is only being carried out in St Johns Hospital and your Psychologist has identified you as a potential participant.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form. If you decide to take part you are free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?
You will be invited to come along to a single session where you will be asked a few brief questions about your current situation and to complete a number of

questionnaires. You will also be asked to complete an exercise where you are required to choose from a set of cards that have different descriptive words on them (for example 'happy' and 'sad') according to how much you feel they apply to you and to other people you know.

The session will take place in the Psychology Department at St Johns Hospital and should take no longer than 1 hour.

Expenses and payments

If you are normally entitled to reimbursement of travel expenses for visits to the hospital, you will also be entitled to these expenses for this one-off appointment.

What do I do once I've made my decision?

If you are willing to take part, please contact me on the number overleaf or complete the tear-off slip below and return it to me in the envelope provided. If I have not heard from you within 7 days you will be sent a short reminder letter just in case you have mislaid the information.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name removed so that you cannot be recognised from it. Your GP and your Psychologist will be contacted and told that you will be taking part in the study. However, details of the outcome of the session will be kept confidential unless at any point during the study we are concerned for your well-being or the well-being of someone else.

What will happen to the results of the research study?

The results of the study will be reported in the lead researcher's doctoral thesis. The thesis is being written as part of training to become a Clinical Psychologist. Once it is completed a copy will be available from the University of Edinburgh Library. People who take part in the study will not be identified in the thesis.

Who has reviewed the study?

The study has been reviewed and approved by the Lothian Research Ethics Committee.

Contact for further information

If you have any questions, or if you would like further information, please feel free to get in touch with me using the contact details on the letterhead.

Many thanks once again for taking the time to read this information sheet.

Susan McAlpine
Trainee Clinical Psychologist
Lead Researcher

✂----------

LREC Ref: 06/S1104/45 DEP Version 2 02.11.06

I wish to take part in the research study 'The ways that women think about other women'.

Name:

Telephone number:

7.5 Appendix: Information sheet

7.5.3 Healthy non-clinical comparison group

LREC Ref: 06/S1104/45 HV version 2 02.11.06

Psychology Department
01506 523615

Participant information sheet

Study Title
The ways that women think about themselves and other women.

Invitation
You are being invited to take part in a research study. Before you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
Studies have shown that some women who experience mental health problems can have negative views of themselves and others. This may lead to problems in everyday social relationships. The study aims to investigate this area further and develop the existing findings. The study will run from autumn 2006 until summer 2007.

Why have I been chosen?
In order to try and understand as much as possible about negative views of self and other people, it is useful to compare the views of women who experience mental health problems with women who don't experience mental health problems. So we also want to ask some healthy volunteers about their views of themselves and other women. You have identified yourself as a potential healthy volunteer.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form. If you decide to take part you are free to withdraw at any time and without giving a reason.

What will happen to me if I take part?
You will be invited to come along to a single session where you will be asked a few brief questions about your current situation and complete a number of questionnaires.

You will also be asked to complete an exercise where you are required to choose from a set of cards that have different descriptive words on them (for example 'happy' and 'sad') according to how much you feel they apply to you and to other people you know.

The session will take place in the Psychology Department at St Johns Hospital and should take no longer than 1 hour.

What do I do once I've made my decision?

If you are willing to take part, please contact me on the number overleaf or complete the tear-off slip below and return it to me in the envelope provided. If I have not heard from you within 7 days you will be sent a short reminder letter just in case you have mislaid the information.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name removed so that you cannot be recognised from it. Your GP will be contacted and told that you will be taking part in the study. However, details of the outcome of the session will be kept confidential unless at any point during the study we are concerned for your well-being or the well-being of someone else.

What will happen to the results of the research study?

The results of the study will be reported in the lead researcher's doctoral thesis. The thesis is being written as part of training to become a Clinical Psychologist. Once it is completed a copy will be available from the University of Edinburgh Library. People who take part in the study will not be identified in the thesis.

Who has reviewed the study?

The study has been reviewed and approved by the Lothian Research Ethics Committee.

Contact for further information

If you have any questions, or if you would like further information, please feel free to get in touch with me using the contact details on the letterhead.

Many thanks once again for taking the time to read this information sheet.

Susan McAlpine
Trainee Clinical Psychologist
Lead Researcher

✂----------

LREC Ref: 06/S1104/45 HV version 2 02.11.06

I wish to take part in the research study 'The ways that women think about other women'.

Name:

Telephone number:

7.6 Appendix: GP information sheet – notice of patient participation

REC Ref: 06/S1104/45

GP/Psychologist/BSA Group Leader Information Sheet Version 2 02.11.06

Psychology Department
Tel: 01506 523615

Date:

Dear _____

RE: Research Project - The ways that women think about themselves and other women.

Your patient _____ address_____ DOB_____

has agreed to take part in the above research project which aims to investigate negative beliefs about self and other women. Please do not hesitate to contact me should you have any questions regarding this or would like some further information.

This project has been approved by the Lothian Research Ethics Committee.

Yours sincerely

Susan McAlpine
Trainee Clinical Psychologist

7.7 Appendix: Contact numbers for the healthy non-clinical comparison group

In case of distress (Healthy Volunteers) Version 1 02.11.06

Psychology Department
Tel: 01506 523615

We would not anticipate that your participation in the research project today should cause you distress. However, if you have any concerns, please raise these with the researcher who will advise you about sources of help and advice. In addition, listed below are some people you can contact yourself, or whom the researcher can contact on your behalf.

Over the coming days or weeks, should you find yourself thinking about any difficult issues as a result of your participation in the research, please do seek advice and support. You may wish to contact:

Mrs Allison Shanks
Clinical supervisor for the project 01506 523615

Mrs Terry Griffiths
Head of Clinical Psychology Services in West Lothian 01506 523615

Your family doctor (who, with your consent, will have been informed of your participation in the study).

7.8 Appendix: Information sheet for Psychologists/Group Leaders

Project title
The perceptions that women who have a history of Childhood Sexual Abuse (CSA) have about themselves and other women.

Aim

To investigate whether women who have a history of CSA, in addition to thinking negatively about themselves, think negatively about other women, and what the precise nature of these views are.

Hypotheses

- Women who have a history of CSA will have negative views of self.
- Women who have a history of CSA will have negative views of other women.
- These views will differ qualitatively and quantitatively from the views of women who are depressed and health volunteers.
- Women who display characteristics of borderline personality disorder will view some women in extremely positive ways and other women in extremely negative ways.

Design
This involves 3 groups, matched on gender and age. 20 women with a history of CSA, 20 women who are currently depressed and 20 women who have no history of childhood sexual abuse and are not currently depressed (healthy volunteers).

Methodology
A self concept sorting task will be used. This involves individuals ascribing positive and negative words to aspects of themselves and others.

They will be asked to attend a single appointment with the researcher. They will be asked for some demographic information and for those with a history of CSA they will ask a few basic questions about the abuse, like age, duration, relationship with the perpetrator, were they able to disclose to anyone at the time.

They will then complete three tasks.

1. Women will be asked to think about themselves in general and choose as many adjectives as they consider appropriate to describe themselves.

2. Women will be asked to think of as many roles that apply to themselves (mother, sister, friend, colleague) and they'll be asked to choose as many adjectives as they consider appropriate to describe themselves in these roles.

3. Women will be asked to list as many other women who have played some kind of part in their life choose as many adjectives as they consider appropriate.

Lastly, women will be asked to complete a number of questionnaires

- The Trauma Symptom Inventory (Briere, 1991) as a measure of distress.
- BDI-II (Beck, 1996) as a measure or depression.
- Rosenberg self esteem inventory (AKA Rosenberg selfconcept) (Rosenberg, 1965)
- Personality Structure Questionnaire (Pollock, 2001) measures sense of self associated with borderline personality disorder.

What you will be asked to do

Identify patients whose primary problem is depression or CSA and give them the appropriate information sheet, which asks them to opt-in to the study by telephoning me in the department or completing a tear-off slip and returning it to me within 7 days.

Ethically I am not allowed to know to whom you have given these information sheets, so I will need you to keep a record of who you've given them to, and at the end of each week I will provide you with some reminder letters. Unfortunately, I then need to ask you to write the address on the envelope yourself. However, apart from remembering to give the information sheets to people in the first place, this is the only thing I should need to ask you to do.

Susan McAlpine 26.06.06

7.9 Appendix: Consent Form

7.9.1 CSA group

REC Ref: 06/S1104/45

Participant Consent Form CSA Version 2 02.11.06

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: The ways that women think about themselves and other women.

Name of Researcher: Susan McAlpine

Please initial each box

1. I confirm that I have read and understood the information sheet dated 02.11.06 for the above study. I have had the opportunity to consider the information and ask questions. I have had these questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐
3. I agree to my GP being informed of my participation in the study. ☐
4. I agree to my Psychologist being informed of my participation in the study. (if applicable) ☐
5. I agree to my BSA group leader being informed of my participation in the study. (if applicable) ☐
6. I agree to take part in the above study. ☐

Name of Participant_____ Date_____

Signature _____

Researcher_____ Date_____

Signature_____

When completed, 1 for participant; 1 for researcher site file; 1 (original) to be kept in notes

☐ Please tick the box if you would like a summary of the research findings to be posted to you once the project has been completed.

7.9 Appendix: Consent form

7.9.2 Depression group

REC Ref: 06/S1104/45

Participant Consent Form DEP Version 2 02.11.06

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: The ways that women think about themselves and other women.

Name of Researcher: Susan McAlpine

Please initial each box

1. I confirm that I have read and understood the information sheet dated 02.11.06 for the above study. I have had the opportunity to consider the information and ask questions. I have had these questions answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I agree to my GP being informed of my participation in the study. ☐

4. I agree to my Psychologist being informed of my participation in the study ☐

5. I agree to take part in the above study. ☐

Name of Participant_____ Date_____

Signature _____

Researcher_____ Date_____

Signature_____

When completed, 1 for participant; 1 for researcher site file; 1 (original) to be kept in notes

☐ Please tick the box if you would like a summary of the research findings to be posted to you once the project has been completed.

7.9 Appendix: Consent form

7.9.3 Healthy non-clinical comparison group

REC Ref: 06/S1104/45

Participant Consent Form HV Version 2 02.11.06

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: The ways that women think about themselves and other women.

Name of Researcher: Susan McAlpine **Please initial each box**

1. I confirm that I have read and understood the information sheet dated 02.11.06 for the above study. I have had the opportunity to consider the information and ask questions. I have had these questions answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I agree to my GP being informed of my participation in the study. ☐

4. I agree to take part in the above study. ☐

Name of Participant_____ Date_____

Signature _____

Researcher_____ Date_____

Signature_____

When completed, 1 for participant; 1 for researcher site file; 1 (original) to be kept in notes

☐ Please tick the box if you would like a summary of the research findings to be posted to you once the project has been completed.

7.10 Appendix: Demographic Questions (all groups)

Basic demographic information

Age

Marital status

Living with family/alone/partner/flatmate etc

Do you have any children?

Employment status

7.11 Appendix: Brief interview questions about history of abuse (CSA group)

About the history of abuse

Single instance of abuse/more than one

Single perpetrator of (each episode) abuse

Relationship with perpetrator(s) of (each episode) abuse

Age at which (each episode) occurred

Duration of (each episode) abuse

Was individual able to disclose information (to family/friend) at any time

7.12 Appendix: Words employed in the card sort test

Showers's adjectives sorted into positive with their corresponding negative

Successful	failure
Giving	self-centred
Capable	incompetent
Confident	insecure
Comfortable	uncomfortable
Independent	indecisive
Needed	unloved
Communicative	disagreeing
Mature	immature
Organised	disorganised
Intelligent	inferior
Lovable	worthless
Interested	tense
Outgoing	isolated
Energetic	weary
Hardworking	lazy
Happy	sad and blue = **sad**
Friendly	irritable
Optimistic	hopeless
(Fun and entertaining)= **fun**	not the real me = replace with **judgemental**

Also add in CSA words:

loving	shameful
attractive	ugly
trustworthy	disgusting
supportive	stupid
strong	doormat

Item Booklet

John Briere, PhD

Please read all of these instructions carefully before beginning. Mark all of your answers on the accompanying answer sheet and write only where indicated. DO NOT write in this item booklet.

On the answer sheet, please write your name, the date, your age, your sex, and your race in the spaces provided.

This questionnaire contains 100 items describing experiences that may or may not have happened to you. Please circle the one answer that best indicates how often each of the following experiences have happened to you **in the last 6 months**.

Circle 0 if your answer is NEVER; it has not happened at all in the last 6 months.	(0)	1	2	3
Circle 1 or 2 if it has happened in the last 6 months, but has not happened often.	0	(1)	2	3
	0	1	(2)	3
Circle 3 if your answer is OFTEN; it has happened often in the last 6 months.	0	1	2	(3)

If you make a mistake or change your mind, **DO NOT ERASE!** Make an "X" through the incorrect response and then draw a circle around the correct response.

Please answer each item as honestly as you can. Be sure to answer every item. You can take as much time as you need to finish the TSI.

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0	1	2	3
Never			Often

In the last 6 months, how often have you experienced:

1. Nightmares or bad dreams
2. Trying to forget about a bad time in your life
3. Irritability
4. Stopping yourself from thinking about the past
5. Getting angry about something that wasn't very important
6. Feeling empty inside
7. Sadness
8. Flashbacks (sudden memories or images of upsetting things)
9. Not being satisfied with your sex life
10. Feeling like you were outside of your body
11. Lower back pain
12. Sudden disturbing memories when you were not expecting them
13. Wanting to cry
14. Not feeling happy
15. Becoming angry for little or no reason
16. Feeling like you don't know who you really are
17. Feeling depressed
18. Having sex with someone you hardly knew
19. Thoughts or fantasies about hurting someone
20. Your mind going blank
21. Fainting
22. Periods of trembling or shaking
23. Pushing painful memories out of your mind
24. Not understanding why you did something
25. Threatening or attempting suicide
26. Feeling like you were watching yourself from far away
27. Feeling tense or "on edge"
28. Getting into trouble because of sex
29. Not feeling like your real self
30. Wishing you were dead
31. Worrying about things
32. Not being sure of what you want in life
33. Bad thoughts or feelings during sex
34. Being easily annoyed by other people
35. Starting arguments or picking fights to get your anger out

0	1	2	3
Never			Often

In the last 6 months, how often have you experienced:

36. Having sex or being sexual to keep from feeling lonely or sad
37. Getting angry when you didn't want to
38. Not being able to feel your emotions
39. Confusion about your sexual feelings
40. Using drugs other than marijuana
41. Feeling jumpy
42. Absent-mindedness
43. Feeling paralyzed for minutes at a time
44. Needing other people to tell you what to do
45. Yelling or telling people off when you felt you shouldn't have
46. Flirting or "coming on" to someone to get attention
47. Sexual thoughts or feelings when you thought you shouldn't have them
48. Intentionally hurting yourself (for example, by scratching, cutting, or burning) even though you weren't trying to commit suicide
49. Aches and pains
50. Sexual fantasies about being dominated or overpowered
51. High anxiety
52. Problems in your sexual relations with another person
53. Wishing you had more money
54. Nervousness
55. Getting confused about what you thought or believed
56. Feeling tired
57. Feeling mad or angry inside
58. Getting into trouble because of your drinking
59. Staying away from certain people or places because they reminded you of something
60. One side of your body going numb
61. Wishing you could stop thinking about sex
62. Suddenly remembering something upsetting from your past
63. Wanting to hit someone or something
64. Feeling hopeless
65. Hearing someone talk to you who wasn't really there
66. Suddenly being reminded of something bad
67. Trying to block out certain memories
68. Sexual problems
69. Using sex to feel powerful or important
70. Violent dreams

0	1	2	3
Never			Often

n the last 6 months, how often have you experienced:

71. Acting "sexy" even though you didn't really want sex
72. Just for a moment, seeing or hearing something upsetting that happened earlier in your life
73. Using sex to get love or attention
74. Frightening or upsetting thoughts popping into your mind
75. Getting your own feelings mixed up with someone else's
76. Wanting to have sex with someone who you knew was bad for you
77. Feeling ashamed about your sexual feelings or behavior
78. Trying to keep from being alone
79. Losing your sense of taste
80. Your feelings or thoughts changing when you were with other people
81. Having sex that had to be kept a secret from other people
82. Worrying that someone is trying to steal your ideas
83. Not letting yourself feel bad about the past
84. Feeling like things weren't real
85. Feeling like you were in a dream
86. Not eating or sleeping for 2 or more days
87. Trying not to have any feelings about something that once hurt you
88. Daydreaming
89. Trying not to think or talk about things in your life that were painful
90. Feeling like life wasn't worth living
91. Being startled or frightened by sudden noises
92. Seeing people from the spirit world
93. Trouble controlling your temper
94. Being easily influenced by others
95. Wishing you didn't have any sexual feelings
96. Wanting to set fire to a public building
97. Feeling afraid you might die or be injured
98. Feeling so depressed that you avoided people
99. Thinking that someone was reading your mind
100. Feeling worthless

TSI™ Answer Sheet

Date _____

Name _____ Identification No. _____ Age _____ Sex _____ Race _____

Fill in your name, the date, and other information above. Follow the instructions in the TSI Item Booklet and enter your ratings on this sheet. Indicate your ratings by circling the appropriate number for each item.

0 Never 1 2 3 Often

1	0 1 2 3	21	0 1 2 3	41	0 1 2 3	61	0 1 2 3	81	0 1 2 3
2	0 1 2 3	22	0 1 2 3	42	0 1 2 3	62	0 1 2 3	82	0 1 2 3
3	0 1 2 3	23	0 1 2 3	43	0 1 2 3	63	0 1 2 3	83	0 1 2 3
4	0 1 2 3	24	0 1 2 3	44	0 1 2 3	64	0 1 2 3	84	0 1 2 3
5	0 1 2 3	25	0 1 2 3	45	0 1 2 3	65	0 1 2 3	85	0 1 2 3
6	0 1 2 3	26	0 1 2 3	46	0 1 2 3	66	0 1 2 3	86	0 1 2 3
7	0 1 2 3	27	0 1 2 3	47	0 1 2 3	67	0 1 2 3	87	0 1 2 3
8	0 1 2 3	28	0 1 2 3	48	0 1 2 3	68	0 1 2 3	88	0 1 2 3
9	0 1 2 3	29	0 1 2 3	49	0 1 2 3	69	0 1 2 3	89	0 1 2 3
10	0 1 2 3	30	0 1 2 3	50	0 1 2 3	70	0 1 2 3	90	0 1 2 3
11	0 1 2 3	31	0 1 2 3	51	0 1 2 3	71	0 1 2 3	91	0 1 2 3
12	0 1 2 3	32	0 1 2 3	52	0 1 2 3	72	0 1 2 3	92	0 1 2 3
13	0 1 2 3	33	0 1 2 3	53	0 1 2 3	73	0 1 2 3	93	0 1 2 3
14	0 1 2 3	34	0 1 2 3	54	0 1 2 3	74	0 1 2 3	94	0 1 2 3
15	0 1 2 3	35	0 1 2 3	55	0 1 2 3	75	0 1 2 3	95	0 1 2 3
16	0 1 2 3	36	0 1 2 3	56	0 1 2 3	76	0 1 2 3	96	0 1 2 3
17	0 1 2 3	37	0 1 2 3	57	0 1 2 3	77	0 1 2 3	97	0 1 2 3
18	0 1 2 3	38	0 1 2 3	58	0 1 2 3	78	0 1 2 3	98	0 1 2 3
19	0 1 2 3	39	0 1 2 3	59	0 1 2 3	79	0 1 2 3	99	0 1 2 3
20	0 1 2 3	40	0 1 2 3	60	0 1 2 3	80	0 1 2 3	100	0 1 2 3

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7.14 Appendix: Rosenberg self esteem scale

Rosenberg Self Esteem Inventory

Initials:..... ID Code..... Date.....

This is a short questionnaire to measure thoughts about yourself. Please indicate whether you strongly agree, agree, disagree, or strongly disagree with each statement by ticking the appropriate box.

	Strongly Agree	Agree	Disagree	Strongly Disagree
On the whole I am satisfied with myself				
At times I think I am no good at all				
I feel I have a number of good qualities				
I am able to do things as well as most other people				
I feel I do not have much to be proud of				
I certainly feel useless at times				
I feel I am a person of worth, at least equal to others				
I wish I could have more respect for myself				
All in all, I am inclined to feel I am a failure				
I take a positive attitude towards myself				

REC Ref: 06/S1104/45.

Appendix 3

PERSONALITY STRUCTURE QUESTIONNAIRE (PSQ)

The aim of this questionnaire is to obtain an account of certain aspects of your personality. People vary greatly in all sorts of ways: the aim of this form is to find out how far you feel yourself to be constant and 'all of a piece' or variable and made up of a number of distinct 'sub-personalities' or liable to experience yourself as shifting between two or more quite distinct and sharply differentiated states of mind.

Most of us experience ourselves as somewhere between these contrasted ways. A *state of mind* is recognised by a typical mood, a particular sense of oneself and of others and by how far one is in touch with, and in control of, feelings. Such states are definite, recognisable ways of being; one is either clearly in a given state or one is not. They often affect one quite suddenly; they may be of brief duration or they last for days. Sometimes, but not always, changes of state happen because of a change in circumstances or an event of some kind.

Please indicate which description applies to you most closely by shading the appropriate circle

Please complete ALL questions	**Shade circles like this: ● Not like this: ⊗ Ø**	**Shade one circle per question only**

THANK YOU FOR YOUR HELP. ALL INFORMATION WILL BE TREATED AS PRIVATE AND CONFIDENTIAL

SHADE ONE CIRCLE PER QUESTION ONLY

	1 Very true	2 True	3 May or may not be true	4 True	5 Very true	
1. My sense of myself is always the same	O	O	O	O	O	How I act or feel is constantly changing
2. The various people in my life see me in much the same way	O	O	O	O	O	The various people in my life have different views of me as if I were not the same person
3. I have a stable and unchanging sense of myself	O	O	O	O	O	I am so different at different times that I wonder who I really am
4. I have no sense of opposed sides to my nature	O	O	O	O	O	I feel I am split between two (or more) ways of being, sharply differentiated from each other
5. My mood and sense of self seldom change suddenly	O	O	O	O	O	My mood can change abruptly in ways which make me feel unreal or out of control
6. My mood changes are always understandable	O	O	O	O	O	I am often confused by my mood changes which seem either unprovoked or quite out of scale with what provoked them
7. I never lose control	O	O	O	O	O	I get into states in which I lose control and do harm to myself and/or others
8. I never regret what I have said or done	O	O	O	O	O	I get into states in which I do and say things which I later deeply regret

7.16 Appendix: Beck Depression Inventory Second Edition (BDI-II)

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

Subtotal Page 1

Continued on Back

11. Agitation

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

10 11 12 A B C D E

Subtotal Page 2

Subtotal Page 1

Total Score

7.17 Appendix: Protocol

1. Researcher introduces herself and participant is thanked for volunteering for the study. Participant is asked if they have any questions regarding the information sheet they were given.

2. Participant is asked to complete and sign consent form.

3. Researcher explains that there are three elements to the session:

- the participant will be asked a few brief demographic questions, like age and who they live with (for CSA they will also be asked a few brief questions about their history of CSA, the kind of initial questions they will have been asked before, like the age at which it happened and how long it went on for.)

- then the participant will be asked to use the words in front of her and think about which words apply to her and the kind of person she is and which words apply to other women who play or have played a part in her life.

- lastly, she will be asked to fill out some questionnaires.

researcher explains that although the information sheet mentions that it will take an hour, the time it takes will depend on how much the participant has to discuss.

4. Participant is asked brief interview questions.

5. Participant is asked to complete the self-concept task on the basis of a general self concept:

Instructions – This task is about describing yourself. In front of you there are 50 cards. Each card has on it a word that we might use to describe ourselves, a trait or characteristic. I'd like you to pick out the traits that you think describe you. You can use as many or as few traits as you wish.***Please let me know if there are any words that you are not familiar with or that you would like me to explain. ***

6. Participant is asked if there are any words that they would normally use to describe themselves that is not present in the pack.

7. Participant is asked to complete the self-concept task for other women they know:

Instructions – This time I would like you to think about women who play or have played a part in your life; this may be positive or negative. It could be your mother, your neighbour, your GP, a woman you see regularly at the corner shop, anyone whom you have or have had some kind of relationship with. I would then

like you to form groups of traits that go together, where each group of traits describes one of these women. You can form as many or as few groups as you want. Each group can contain as few or as many traits as you wish. You don't have to use every trait, only those that you feel describe one of these women. Also each trait can be used in more that one group, so you can keep re-using traits in different groups as many times as you like.

8. Participant is asked if there are any adjectives that they would normally use to describe any of these women that is not present in the pack.

9. Participant is asked how important each women is to them on a scale of 1 to 7 where 1 is not at all important and 7 is very important (how important were they in the past).

10. Participant is asked how positive or negative an influence this person is (or was) in their life where 1 is very negative and 7 is very positive.

11. Participant is to complete the self concept task with regard to the different aspects of themselves:

Instructions - I would like you to think of the different aspects of yourself and your life and then form groups of traits that go together, where each group of traits describes an aspect of yourself or your life. You can form as many or as few groups as you want. Each group can contain as few or as many traits as you wish. You don't have to use every trait; only those that you feel describe an aspect of you. Also each trait can be used in more that one group, so you can keep re-using traits in different groups as many times as you like.

12. Participant is asked if there are any adjectives that they would normally use to describe any of these aspects of themselves that is not present in the pack.

13. Participant is asked how important this self-aspect is to them on a 7-point scale from not at all important to very important.

14. Participant is asked how positive or negative this role is for them.

15. Participant is asked to complete the 4 questionnaires.

7.18 Appendix: Non-significant result: employment status of CSA and depression groups

Crosstabs

[DataSet1] M:\thesis\small.sav

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
type of participant * employcol	36	100.0%	0	.0%	36	100.0%

type of participant * employcol Crosstabulation

Count

		employcol		Total
		unemployed	employed	
type of participant	CSA	8	12	20
	dep	10	6	16
Total		18	18	36

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.800[b]	1	.180		
Continuity Correction[a]	1.013	1	.314		
Likelihood Ratio	1.816	1	.178		
Fisher's Exact Test				.315	.157
Linear-by-Linear Association	1.750	1	.186		
N of Valid Cases	36				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.00.

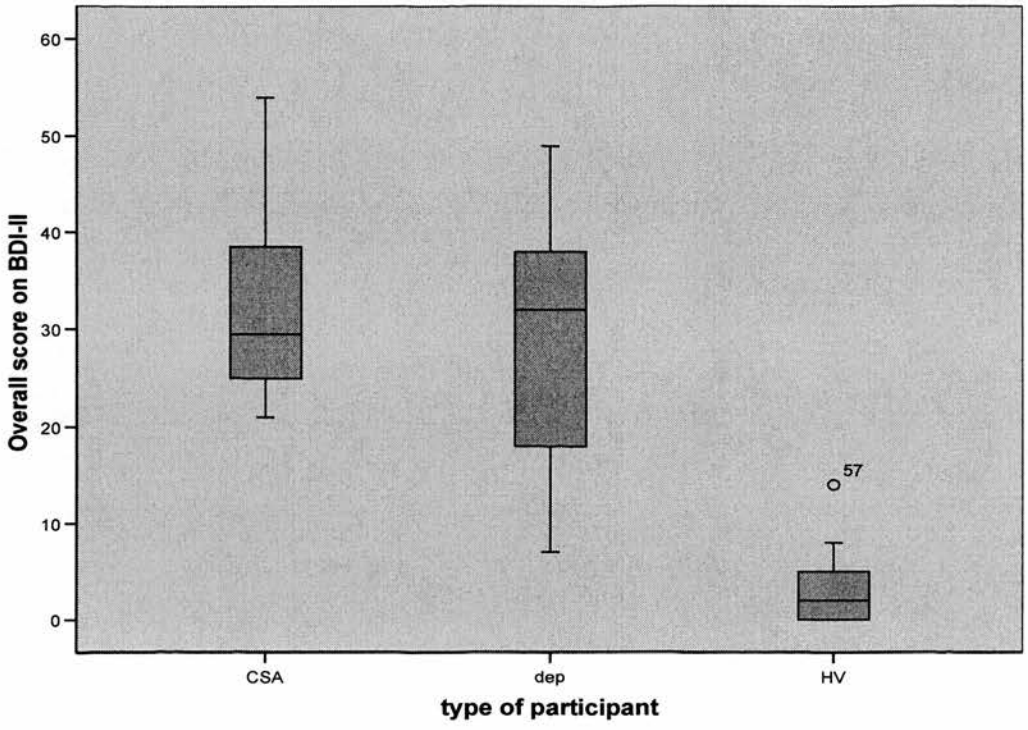
Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.218	.180
N of Valid Cases		36	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

7.19 Appendix: Boxplot of BDI- II scores (outlier)



7.20 Appendix: Non-significant result – other women discussed

Oneway

Descriptives

total number women discussed

		CSA	dep	HV	Total
N		20	16	34	70
Mean		4.50	3.94	4.68	4.46
Std. Deviation		2.212	1.482	2.011	1.961
Std. Error		.495	.370	.345	.234
	Lower Bound	3.46	3.15	3.97	3.99
	Upper Bound	5.54	4.73	5.38	4.92
Minimum		1	2	2	1
Maximum		10	7	10	10

ANOVA

total number women discussed

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	5.993	2	2.996	.774	.465
Within Groups	259.379	67	3.871		
Total	265.371	69			

7.21 Appendix Boxplot of CSA words describing sister (outlier)